Outpatient Specialty
Mental Health Services (SMHS)

Clinical Documentation Guide

2025

CalMHSA

California Mental Health Services Authority

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Introduction to this Guide

The California Medi-Cal system is working to build a more coordinated, person-centered, and equitable health system that works for everyone. The goal of this transformation is for individuals to have access to new and improved services, to receive well-rounded care that goes beyond the doctor office or hospital, and to address physical and mental health needs.

The intent of this documentation guide is to support implementation of the California Department of Health Care Services (DHCS) guidance around essential documentation requirements for specialty mental health services (SMHS) as well as care coordination between the Mental Health Plan (MHP) and Managed Care Plan (MCP) service delivery systems (e.g., screening, transition of care, and service referrals). Information from multiple guides has been complied and condensed into a single comprehensive resource for all SMHS providers.

Health Care Systems

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

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

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

SDOH contribute to health disparities and inequities by limiting access to fundamental resources aimed at supporting health and wellness. For example, if behavioral health services are offered in one part of town that is difficult to access, those who live far away or have transportation challenges may not receive the services they need in a timely fashion. Or perhaps the same clinic does not employ direct service staff who speak the language or understand the culture of the individual seeking care. This, again, impacts an individual's ability to receive care that meets their unique needs. Lastly, we have witnessed the harsh realities of inequities revealed by the COVID-19 pandemic, with stark differences in outcomes including mortality seen along racial/ethnic lines, socioeconomic status, and educational attainment.[1] Medi-Cal behavioral health delivery systems must work to address disparities by enhancing

[1] Variation in Covid-19 Mortality in the US by Race and Ethnicity and Educational Attainment: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2786466

community partnerships and fostering better coordination among systems. This involves breaking down barriers to accessing essential services, identifying and addressing SDOH that have been overlooked, and promoting trauma-informed care that considers the entirety of an individual's experience. Although there are statewide efforts aimed at addressing health disparities, there is still much to be done. As providers, we have a responsibility to look within our organizations and advocate for changes that help reduce or eliminate disparities within health systems. Through this diligent attention, systems can transform to best meet the needs of the people they are intended to serve.

Medi-Cal Programs

In California, DHCS is the state agency responsible for administering the state's Medicaid program, known as Medi-Cal in California. Medi-Cal operates under a combination of federal and state regulations. At the federal level, it is governed by Medicaid laws, which set minimum standards for coverage, eligibility, and benefits. However, each state also has the flexibility to design its own program within those federal guidelines. This allows California to tailor Medi-Cal to meet the unique needs of its residents, resulting in a program that serves approximately 15.5 million people, or about one-third of the state's population. Medi-Cal provides coverage for 40 percent of children and youth, and half of individuals with disabilities in California.[2]

Medi-Cal behavioral health services are "carved out," meaning that they are managed separately from the general Medi-Cal health plans. Instead of receiving these services through their usual Medi-Cal plan, individuals (also referred to as "members") access them through specialized programs run by counties and specific networks. For example, county MHPs provide care for serious mental health conditions, while the Drug Medi-Cal Organized Delivery System (DMC-ODS) offers a range of substance use disorder (SUD) treatments. This approach ensures that individuals get the specialized care they need from providers with expertise in these areas.

[2] https://www.dhcs.ca.gov/dataandstats/statistics/Pages/Fast_Facts.aspx

Additionally, it allows for better coordination with other health care services, ensuring that all aspects of an individual's health are addressed comprehensively. This structure aims to improve access to care, enhance service quality, and ultimately lead to better health outcomes for those enrolled in Medi-Cal. While the purpose of this guide is focused on SMHS and the role of MHPs in providing these services, this section will briefly discuss the broader behavioral health system, including Managed Care Plans (MCPs), Drug Medi-Cal (DMC), and DMC-ODS.

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

SMHS Mental Health Plans

SMHS are managed locally by county MHPs. Fifty-six county MHPs are contracted with DHCS to administer the Medi-Cal SMHS benefit. In addition to managing the benefit, MHPs directly deliver and/or contract with community-based organizations (CBOs) or group/individual providers to deliver an array of services designed to meet the needs of individuals with Medi-Cal who have significant and/or complex care needs — includes intensive services and programs, such as therapy, community-based services and intensive case management programs. The term “case management” is used at different points because this service type is defined in federal regulation for SMHS.[3] However, it is important to remember that each individual in care is not a “case” to be managed, but rather a human being with care needs. (See Appendix II for a list of covered services.)

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

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

California counties administer Substance Use Disorder (SUD) services through one of two systems: Drug Medi-Cal (DMC) or the Drug Medi-Cal Organized Delivery System (DMC-ODS). While both systems provide SUD treatment to Medi-Cal beneficiaries, they differ in their service offerings and operational requirements.

Under DMC, counties offer a set of defined services, including Narcotic Treatment Program services, Outpatient Drug-Free services, Intensive Outpatient Treatment (IOT), Perinatal Residential Substance Use Disorder services, Naltrexone Treatment services, Mobile Crisis services and Justice Involved Reentry services. DMC-ODS, in contrast, is an opt-in program that allows counties to provide an expanded continuum of care for Medi-Cal-eligible individuals with SUD. It is designed to align with the American Society of Addiction Medicine (ASAM)

[3] https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-440/subpart-A/section-440.169

Criteria® and incorporates additional elements such as increased local oversight, utilization management, evidence-based treatment practices, and enhanced coordination with other systems of care. Counties that participate in DMC-ODS offer a broader range of SUD services beyond those available under DMC. Covered services for each system are provided in Appendix II.

Managed Care Plans

Managed care plans (MCPs) are responsible for the majority of the physical health care benefits and non-specialty mental health services (NSMHS) for individuals. The MCPs provide mental health services to members with less significant or complex care needs and, therefore, may provide a lower frequency/intensity of mental health services. In terms of mental health treatment, MCPs provide medication evaluation and treatment, group and individual therapy, psychological testing, as well as prescription medications, including psychotropic medications. For SUD, MCPs provide Screening, Brief Intervention and Referral to Treatment (SBIRT) and Medication Assisted Treatment (MAT) (see Appendix II for a list of covered services). MCPs may operate within one county or across an entire region and deliver services across a managed network of providers (hospitals, Federally Qualified Health Centers, and other organizations). Some counties may have multiple MCPs in one county, and Medi-Cal members can choose which MCP they would like to belong to. In other counties, there may be a single MCP providing coverage to all Medi-Cal members. To find out which MCPs provide coverage in which county, check the DHCS website. All systems discussed here — MHPs, DMC/DMC-ODS, and MCPs — administer and/or deliver an array of services to Medi-Cal members. Given the complexity of the systems, it can be difficult for individuals seeking services to understand which plan would best treat their behavioral health care needs and where/how to access SMHS, DMC/DMC-ODS, or NSMHS. To simplify navigating this complex system for people seeking services, DHCS has provided guidelines for accessing medically necessary care.

Definition of Medical Necessity

All Medi-Cal services provided to individuals in care need to meet the standard of being “medically necessary.” The definitions of medical necessity are somewhat different, based upon the age of the individual in care. For individuals 21 and older, a mental health service is considered medically necessary when it is “reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.”[4] For individuals under 21, the definition of medically necessary falls under the Early and Period Screening, Diagnostic and Treatment (EPSDT) Services language under a specific section of Title 42 [5] This section requires provision of all Medicaid (Medi-Cal) coverable services necessary to correct or ameliorate a mental illness or condition discovered by a screening service, whether or not the service is covered under the State Plan. These services need not be curative or restorative, and can be delivered to sustain, support, improve, or make more tolerable a mental health condition.

Access to the Specialty Mental Health System

Following are the technical criteria for accessing SMHS through the MHP; we encourage providers to continue to view the information with empathy, considering the perspective of the individual in care and prioritizing their voice in all health care decisions.

The following criteria are for two distinct age cohorts: individuals 21 years and older and individuals under 21 years of age. Each of these cohorts has distinct criteria due to their

[4] Welfare and Institutions Code §14059.5

[5] Section 1396d(r) of Title 42 of the United States Code

developmental needs.[6] It is important to note early on that individuals can start receiving clinically appropriate services as long as they would benefit from SMHS, even if a final diagnosis eligibility determination has not yet been made.

Overview of criteria to access SMHS for adults 21 years and older

Both of the following criteria must be met:

- The person has significant impairment (defined as distress, disability, or dysfunction in social, occupational, or other important activities) and/or there is reasonable probability of significant deterioration in an important area of life functioning.
- The condition identified above is due to a diagnosed mental health disorder according to the most current edition of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems or a suspected mental disorder that has not yet been diagnosed.

Overview of criteria to access SMHS for persons under 21 years of age

- The person has a condition placing them at high risk for mental health disorder due to trauma evidenced by any of the following: scoring in the high-risk range under trauma screening tool approved by DHCS, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness.

OR, both of the following criteria must be met:

- The person has a significant impairment, a reasonable probability of significant deterioration in an important area of life functioning, a reasonable probability of not progressing developmentally as appropriate, or a need for SMHS (regardless of impairment) that are not included within the mental health benefits of MCPs.
- The condition identified above is due to a diagnosed mental health disorder according to the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Statistical Classification of Diseases and Related Health Problems, a suspected mental health disorder that has not yet been diagnosed, or significant trauma placing the person at risk for a future mental health condition, based on the assessment of a licensed mental health professional.

Treatment Sequence

Treatment typically follows a specific sequence to ensure that individuals in care receive the best possible support and outcomes. This structured approach allows for thorough evaluation and tailored interventions, facilitating continuity and coordination among providers. We will cover each part in detail, highlighting its importance in the overall process. The sequence typically progresses as follows: Screening, Assessment, Problem List, Care Coordination, Treatment, Care Transitions, and Discharge. Each of these components plays a crucial role in delivering comprehensive and effective care.

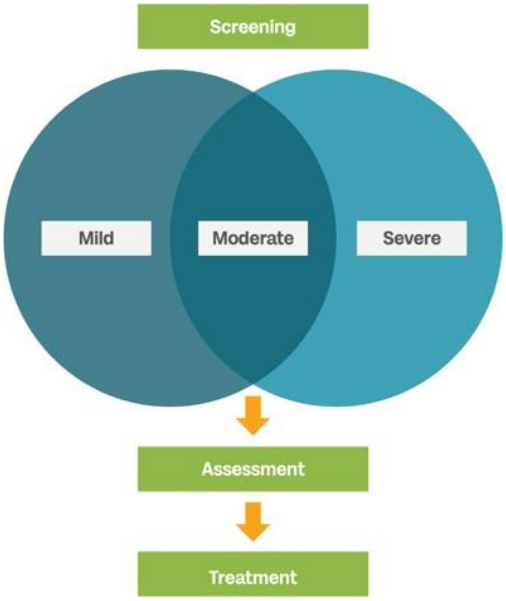
Screening

Individuals seeking care may access treatment in several different ways including self-referral, referral from another behavioral health provider, or a primary health care provider, etc. No matter how an individual initiates care, the individual can expect to receive timely mental health services whether from an MHP or through the MCP. If we keep the individual's care needs at

[6] DHCS Behavioral Health Information Notice (BHIN) No: 21-073

the forefront of treatment decisions, there is no wrong door through which the individual may enter. The goal is to ensure that individuals seeking care have access to the right care in the right place at the right time. To support these efforts, standardized screening tools were developed by DHCS. Those tools will be discussed further in the next section.

Standardized Screening Tools[7]



DHCS created standardized screening tools — one for adults 21 and older, and one for youth under age 21. The purpose of these screening tools is to determine the appropriate Medi-Cal mental health delivery system to refer an individual to when they are not already receiving mental health services from the MHP or MCP. Medi-Cal MCPs and county MHPs are both required to use the standardized screening tools when contacted by an individual who is seeking mental health services for the first time, or when an individual is reaching out on behalf of someone under age 21 to obtain mental health services for the first time.

If an individual seeking care contacts a community-based or county contracted provider directly, the provider may begin the assessment process and provide services during the assessment period without using the screening tools (consistent with the No Wrong Door for Mental Health Services Policy[8]) If a provider (e.g., a primary care physician or school nurse) refers an individual to an MCP for NSMHS or to an MHP for SMHS based on an understanding of the individual's needs, the MCP/MHP is not required to use the screening tools. In these scenarios, MCPs and MHPs should follow existing protocols for provider referrals and begin the assessment process. Alternatively, if a third party (including but not limited to a health care provider) simply connects the individual to the MCP/MHP as a resource (e.g., gives them the MCP/MHP phone number for more information about what services may be available to them) without having conducted a screening or brief assessment to determine the appropriate delivery system for referral, the screening tool must be used.[9]

Screening Tool Administration

The screening tools are designed to be administered by both non-clinicians and clinicians, and do not require clinical judgment to complete. They may be administered in person, over the phone, or in a community setting. The specific wording and ordering of the questions/fields in the tools must remain intact, and the scoring methodology for the screening tools may not be altered. DHCS has provided copies of translated screening tools, which can be found here.

There may be instances where the person administering the screening is asked to clarify a question so that the individual being screened can respond. MCPs and MHPs are expected to train staff on responses to requests for clarification that are aligned with the intent of the question(s) and existing internal policies.

The adult tool contains 14 questions, and the youth tool contains 23 questions. If a provider is conducting a screening with an individual on behalf of a youth under age 21, the provider must use the "Respondent on Behalf of Youth" version of the tool. If an individual responds

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[7] DHCS Behavioral Health Information Notice (BHIN) No: 25-020
[8] DHCS Behavioral Health Information Notice (BHIN) No: 22-011
[9] DHCS Behavioral Health Information Notice (BHIN) No: 25-020

affirmatively to certain questions (e.g., emergency, suicidality, homicidality, already receiving mental health services from the MCP or MHP, certain youth access criteria), the screening must be discontinued, and the provider must complete appropriate next steps as indicated in the tool.

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

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

In certain circumstances, some practitioner types may override the Screening Tool Score when the result is inconsistent with the member's clinical presentation. For example, the Screening Tool score may not reflect the need for SMHS in situations where a member is unable to answer the questions accurately due to severe mental health symptoms, such as active psychosis or severe disorganization.

If a provider decides to override the Screening Tool score, they must document their rationale and supporting information, indicating either that additional screening information supports a higher level of services than NSMHS or a lower level of services than SMHS. Overrides and the rationale need to be recorded through the preferred monitoring method (EHR, excel spreadsheet, etc.) and shared with the appropriate Medi-Cal mental health delivery system following the administration of the Screening Tool. Overrides of the Screening Tools are subject to auditing and BHPs must provide the records, including the override rationale (e.g., EHR, excel spreadsheet, etc.), to DHCS upon request.

While the Screening Tool can be completed by any clinician or non-clinician, overriding the Screening Tool score can only be conducted by the following practitioners:

- Registered Nurses
- Physician Assistants
- Licensed Physicians
- Licensed Psychologists
- Licensed Clinical Social Workers
- Licensed Professional Clinical Counselors
- Licensed Marriage and Family Therapists
- Licensed Occupational Therapists
- The waivered, registered or clinical trainee counterparts of the practitioner types listed above.

Please note that providers who are not authorized to override the Screening Tool score may not

request or rely on an allowable provider type to complete the override on their behalf. In these cases, the provider should simply complete the tool as directed and follow the standard procedures.

Assessment

Once the Screening Tool has been administered, an individual seeking care may receive a referral for an assessment by a Licensed Practitioner of the Healing Arts (LPHA). DHCS requires the use of a standard assessment that includes the seven domains discussed below. Additional assessments may also be done based on the age of the individual seeking care and/or current treatment needs. During an assessment, an LPHA develops a clinical understanding of the individual's care needs, determines an accurate diagnosis, confirms the appropriate treating system, and what services are medically necessary to support the individual in their goals so they can thrive in their community. Because human beings are complex, an assessment may take more than one session to fully determine the overall care needs. For some individuals completing an assessment may include collecting information from collateral sources including, but not limited to, family members and other natural support persons, previous service providers, and/or external system partners. While the assessment is in process, the individual in care may simultaneously receive additional clinically appropriate and medically necessary services such as therapy, rehabilitation, case management, medication support, etc. These services are reimbursable under Medi-Cal even when[10]:

1. The services are provided prior to determination of a diagnosis, during the assessment process, or prior to determination of whether SMHS access criteria are met.
2. Remember that, while a mental health diagnosis is not a prerequisite for access to covered services, and while an individual may access necessary services prior to determining a diagnosis, an ICD-10[11] code must be assigned to submit a service claim for reimbursement. More information on appropriate ICD-10 codes prior to the determination of a mental health diagnosis can be found in the next section.
3. The individual in care has a co-occurring mental health condition and SUD; or
4. NSMHS and SMHS are provided concurrently, if those services are coordinated and not duplicative.

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

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[10] Welfare & Institutions Code 14184.402(f)

[11] DHCS Behavioral Health Information Notice (BHIN) No: 22-013 and https://www.cms.gov/medicare/coding-billing/icd-10-codes

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

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

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

Standardized Assessment Requirements (Including Timeliness)

Before reviewing the seven required domains of SMHS assessments, below is a summary of additional requirements that must be considered when completing and documenting assessments.

For individuals between the ages of 6 and 20, the Child and Adolescent Needs and Strengths (CANS) assessment tool, and for individuals aged 3 through 18 the Pediatric Symptom Checklist (PSC-35) are required in addition to the standardized assessment. Please note that an initial CANS shall be completed or an existing CANS shall be updated by a CANS certified provider.[12]

- Assessments for SUD for individuals of all ages shall include the ASAM criteria when an assessment is made to determine the appropriate treatment level of care.[13]
- Findings gathered while using these additional tools may be included as part of the standard assessment domain requirements.
- The time period for providers to complete an initial assessment and subsequent assessments for SMHS is up to clinical discretion; however, providers shall complete assessments within a reasonable time and in accordance with generally accepted standards of practice and an individual's clinical needs.
- Services provided prior to determination of a diagnosis, during the assessment, or prior to determination of whether NSMHS or SMHS access criteria are met are covered and reimbursable, even if the assessment ultimately indicates the individual does not meet criteria for SMHS.
- The assessment shall include a typed or legibly printed name, title or credentials, signature of the service provider and date of signature. Please note that providers using an electronic health record (EHR) will likely find that the EHR captures their signature and the signature date when the provider finalizes a service note.

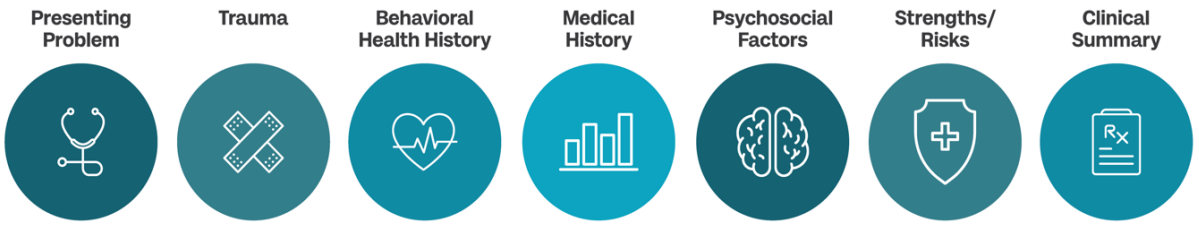
[12] DHCS Behavioral Health Information Notice (BHIN) No:17-052
[13] DHCS Behavioral Health Information Notice (BHIN) No: 24-001

- The assessment shall include the licensed provider's recommendation and determination of medical necessity for services. The problem list and progress note requirements identified below shall support the medical necessity of each service provided.
- The diagnosis, mental status exam, medication history, and assessment of relevant conditions and psychosocial factors affecting the person's physical and mental health must be completed by a provider, operating in their scope of practice under California law, who is licensed, registered, waivered, and/or under the direction of a licensed mental health professional as defined in the State Plan.[14]
- Both licensed and non-licensed providers, including those not qualified to diagnose a mental health condition, may contribute to the assessment consistent with their scope of practice as described in the State Plan.[15]

Assessment Domain Requirements[16]

The assessment contains universally required domains that should not vary from MHP to MHP or CBO to CBO. Below is information on the standardized domains comprising the assessment for understanding the individual's care needs. A domain is a reference to categories of information that should be captured within the SMHS assessment. To the extent the information is available, all components listed within each of the seven domains shall be included as part of a comprehensive assessment. While each of the domains is required and must be addressed, information may overlap across domains. When conducting an assessment, it is important to keep in mind the flow of information and avoid duplication to ensure a clear and ideally chronological account of the individual's current and historical need is accurately documented. Include the perspective of the individual and, whenever possible, use their quotes within the document.

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



Presenting Problem(s)/Chief Complaint (Domain 1)

[14] https://www.dhcs.ca.gov/formsandpubs/laws/Documents/Supp1toAtt3.1-A98-16%20(10-012B).pdf
[15] www.dhcs.ca.gov/formsandpubs/laws/Documents/Supp3-to-Attach3-1-A.pdf; www.dhcs.ca.gov/SPA/Documents/Supplement-2-to-Attachment-3-1-B.pdf

[16] DHCS Behavioral Health Information Notice (BHIN) No.: 23-068

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

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

Trauma (Domain 2)

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

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

Behavioral Health History/Co-occurring Substance Use: (Domain 3)

child welfare system.

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

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

Medical History/Current Medications/Co-occurring Conditions: (Domain 4)

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

- **Medical History –** Relevant current or past medical conditions, including the treatment history of those conditions. Information on help seeking for physical health treatment should be included. Information on allergies, including those to medications, should be clearly and prominently noted.
- **Current Medications –** Current medications, including prescribing clinician, reason for medication usage, dosage, frequency, adherence, and efficacy/benefits and side effects of medications. When available, the start and end dates or approximate time frames for medication should be included.
- **Co-occurring Conditions (other than substance use) -** Indicate any co-occurring medical or mental health conditions that the individual is experiencing, excluding substance use disorders.

Social and Life Circumstances/Culture/Religion/Spirituality (Domain 5)

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

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

Strengths, Risk Behaviors and Protective Factors (Domain 6)

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

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

Clinical Summary and Recommendations/Diagnostic Impression/Medical Necessity Determination,/Level of Care (LOC)/Access Criteria (Domain 7)

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

- **Clinical Summary** – Summary of clinical symptoms supporting diagnosis, functional impairments (clearly connected to symptoms/presenting problem), history, mental status exam, cultural factors, strengths/protective factors, risks, and any hypothesis regarding predisposing, precipitating and/or perpetuating factors to inform the problem list (to be explained further below).
- **Diagnostic Impression** – Clinical impression, including any current medical diagnoses and/or diagnostic uncertainty (rule-outs, provisional, or unspecified diagnoses).

- **Treatment Recommendations** – Recommendations for detailed and specific interventions and service types based on clinical impression and overall goals for care.[17]
- **Medical Necessity Determination/LOC/Access Criteria –** Criteria used to determine eligibility for SMHS, the appropriate level of care, and the medical necessity requirements.

Diagnosis

Information used to determine a diagnosis is obtained through the clinical assessment and structured tools that we have discussed. Information that informs the individual's diagnosis may come directly from the individual or through other means, such as collateral information or health records. A diagnosis captures clinical information about the individual's mental health needs and other conditions based on the most current version of the DSM. Diagnoses are determined by an LPHA commensurate with their scope of practice (see Appendix III for scope of practice grid). Diagnoses are used to communicate with other team members about the individual's mental health symptoms and other conditions and may document the level of distress/impairment. Diagnoses also help guide providers in their advisement about treatment options to the individual.

Diagnoses may change over time. For example, the individual's clinical presentation may change over time and/or the provider may receive additional information about the individual's symptoms and how the individual experiences their symptoms(s) and conditions. As a provider, it is your responsibility to document all diagnoses, including preliminary diagnostic impressions and differential diagnoses as well as to update the health record of the individual whenever a diagnostic change occurs.

While there is no longer a limited set of diagnosis codes that are allowable in relation to the provision of SMHS, the covered benefits and service responsibilities of the MHPs and MCPs remain unchanged. For example, MHPs are not required to provide Applied Behavior Analysis (ABA), a key intervention in the treatment of autism spectrum disorder (ASD), as the responsibility for providing that service remains with the MCP. However, an individual in care who has ASD is also able to receive treatment from the MHP if their service needs require it and services would not be duplicative with the other care they are receiving.

Provisional Diagnosis Options

Providers may use the following options during the assessment phase of an individual's treatment when a diagnosis has yet to be established:[18]

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

[17] DHCS Behavioral Health Information Notice (BHIN) No.:21-073
[18] DHCS Behavioral Health Information Notice (BHIN) No: 22-013

code.[19] For example, these include codes for “Other specified” and “Unspecified” disorders,” or “Factors influencing health status and contact with health services.”

The Problem List

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

The problem list is a list of symptoms, conditions, diagnoses, social drivers, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters. A problem identified during a service encounter may be addressed by the service provider during that service encounter and subsequently added to the problem list. The providers responsible for the person’s care create and maintain the problem list. The problem list includes clinician-identified diagnoses, identified concerns of the individual in care, and issues identified by other service providers including those by MHRS, Peer Support Specialists, and other treatment team members. The problem list helps facilitate continuity of care by providing a comprehensive and accessible list of problems to quickly identify the person’s care needs, including current diagnoses and key health and social issues.

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

Problem lists will have ICD-10 codes including Z codes, as well as SDOH codes.[20] DHCS has identified a list of priority SDOH codes to facilitate the collection of reliable SDOH information for the Medi-Cal population. These codes are found in Appendix IV along with a link to all Z codes.

[19] https://www.cms.gov/medicare/coding-billing/icd-10-codes

[20] DHCS Behavioral Health Information Notice (BHIN) No: 23-068

Problem List Requirements

The problem list shall be updated on an ongoing basis to reflect the current presentation of the individual in care. Providers shall add to or remove problems from the problem list when there is a relevant change to an individual's condition. For individuals that were receiving services prior to July 1, 2022, a problem list is not required to be created retroactively. However, a problem list should be started when the individual receives a subsequent SMH, DMC, or DMC-ODS service.

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

- Diagnoses identified by a provider acting within their scope of practice
- Diagnostic specifiers from the current DSM, when applicable
- Problems identified by a provider acting within their scope of practice
- Problems or illnesses identified by the individual in care and/or significant support person, if any
- The name and title of the provider that identified, added, or removed the problem, and the date the problem was identified, added, or resolved

It is important to note that providers may add items to problem lists that are outside their scope of practice, including, but not limited to, physical health conditions, if they are reported to the provider by the individual or by another qualified professional. For example, a primary care physician may diagnose a chronic physical health condition and share that information with the mental health or SUD provider. The mental health provider may update the problem list to include the physical health diagnosis. The member record may include information on when, by whom, and to whom the issue was reported.

DHCS does not require the problem list to be updated within a specific time frame, nor is there a specific requirement for how frequently the problem list should be updated. However, providers shall update the problem list within a reasonable time and in accordance with generally accepted standards of practice.

Accurate diagnoses and a comprehensive problem list are crucial for delivering appropriate treatment and supporting service claims. Inconsistencies in these areas can result in poor care coordination across teams and inadequate documentation of medical necessity, potentially leading to rejected claims.

Example of a Problem List for a Person in Care

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

*Name and provider title will likely be automatically populated by your EHR.

Treatment/Care Plan Requirements

Wherever possible, DHCS eliminated detailed care plan requirements for mental health and SUD services. In some instances, due to existing state or federal requirements, DHCS was unable to completely remove these requirements. Below you will find examples of outpatient specialty mental health services that still require care plans. For a complete list of services with care planning requirements, please refer to Enclosure 1a of BHIN 23-068.

In addition to care planning requirements, there may be program or facility types that are required to comply with additional program/facility-specific regulations. It is recommended to refer to program-specific materials for program/facility-specific regulations. Licensed and Certified Social Rehabilitation Programs and providers of SUD residential treatment are among the programs/facilities that must observe care planning requirements that appear elsewhere in state law or policy.

To determine whether a care plan is required for a particular behavioral health service, follow these steps:

1. Does the program, service, or facility type have state or federal care planning requirements that remain in effect (see Enclosure 1a of BHIN 23-068 for a non-exhaustive list)?
    a. If yes, continue to step 2.
    b. If no, there are no care planning requirements to follow. DHCS will not monitor or enforce the use of formal care plans, or documentation of specific care planning activities.
2. Review the relevant state and/or federal guidance to identify specific requirements (e.g., care planning activities) included in Enclosure 1a of BHIN 23-068. Some of these care planning requirements are more detailed/specific than others.
3. Adhere to all relevant care planning requirements in state and federal law.
4. Document the required care plan/care planning activities within the member record. DHCS allows providers to choose where within the member record to document care planning information required by state or federal law (e.g., within a care plan template, in progress notes, or in a combination of locations or formats).
5. Produce and communicate the content of the care plan to other providers, the individual, and Medi-Cal delivery systems as needed to facilitate coordinated, high-quality care for Medi-Cal members.

The following outpatient programs or services still require a care plan:

A. Targeted Case Management (TCM)

TCM services require the development (and periodic revision) of a specific care plan based on the information collected through the assessment, that includes the following:[21]

- Specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual.
- Includes activities such as ensuring the active participation of the eligible individual and

[21] https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-440/subpart-A/section-440.169

working with the individual (or the individual's authorized health care decision maker) and others to develop those goals.

- Identifies a course of action to respond to the assessed needs of the eligible individual.

Per BHIN 23-068, The Centers for Medicare and Medicaid Services (CMS) has approved the following: "DHCS' new documentation standards outlined in BHIN 22-019, or any subsequent guidance require providers to incorporate the TCM care plan elements outlined in 42 CFR § 440.169(d)(2) into the clinical record. Under the new standards for SMHS, care planning is documented through a treatment plan or a combination of the assessment record, a problem list, progress notes, or another section of the clinical record for each encounter."[22]

B. Intensive Care Coordination (ICC)

The difference between ICC and the more traditional TCM service functions is that ICC is intended for children and youth with more intensive needs, and/or whose treatment requires cross agency collaboration. Requirements for ICC care planning are discussed in the Medi-Cal Manual for ICC, Intensive Home-Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries.[23] Like TCM, ICC care planning can be documented through a treatment plan or a combination of the assessment record, a problem list, progress notes, or another section of the clinical record for each encounter.

C. Medi-Cal Peer Support Services

Medi-Cal Peer Support Services are an optional benefit for counties. Services are culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities. Services aim to prevent relapse, empower individuals through strength-based coaching, support linkages to community resources, and to educate individuals and their families about their conditions and the process of recovery. Medi-Cal Peer Support Services must be based on an approved plan of care. The plan of care shall be documented within the member record and approved by any treating provider who can render reimbursable Medi-Cal services. Medi-Cal Peer Support Services must be coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals. Providers should use a person-centered planning process to help promote participant ownership of the plan of care. Such methods actively engage and empower the participant, and individuals selected by the participant, in leading and directing the design of the service plan and, thereby, ensure that the plan reflects the needs and preferences of the participant in achieving the specific, individualized goals that have measurable results and are specified in the service plan.[24]

D. Therapeutic Behavioral Services (TBS)

Therapeutic Behavioral Services are intensive mental health services available to children and youth under the age of 21 who are Medi-Cal members and meet certain criteria related to their mental health needs. TBS is provided to children/youth with serious challenges who are

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[22] (Section 1915(b) Waiver Proposal for California Advancing and Innovating Medi-Cal (CalAIM), Amendment Submitted November 4, 2022, Updated June 23, 2023

[23] Medi-Cal Manual for ICC, IHBS, and TFC Services for Medi-Cal Beneficiaries, Third Edition, January 2018

[24] https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/smd081507a.pdf

experiencing behaviors or symptoms that put them at risk of psychiatric hospitalization, or have had a recent hospitalization, or are being considered for placement in a higher-level group home or locked facility.[25] TBS can help children/youth and parents/caregivers, foster parents, group home staff, and school staff learn new ways of reducing and managing challenging behaviors as well as strategies and skills to increase the kind of behavior that will allow children/youth to be successful in their current environment.[26] TBS is intended to help children/youth manage behaviors or symptoms using short-term, measurable goals based on the needs of the youth and family. TBS is never a stand-alone therapeutic intervention and is meant to be delivered in conjunction with other mental health services, such as Intensive Care Coordination (ICC), therapy, or medication services.

TBS client plans can be either separate plans or part of a more comprehensive plan. The TBS client plan provides clinical direction for short-term intervention(s) to address specific behaviors of the child/youth that were identified in the TBS assessment. Interventions that directly address the behaviors identified during the assessment process are the key component necessary to developing an effective TBS client plan. Interventions may be modified over time based on the degree of effectiveness of the intervention strategy and the child/youth's changing behaviors and needs. TBS client plans provide a detailed description of the treatment including behavior modification strategies for the child/youth.

TBS client plans should include all of the following:

- Targeted Behaviors: Clearly identified specific behaviors that jeopardize the residential placement or transition to a lower level of residential placement and that will be the focus of TBS.
- Plan Goals: Specific, observable quantifiable goals tied to the targeted behaviors.
- Benchmarks: The objectives that are met as the child/youth progresses toward achieving client plan goals.
- Interventions: Proposed intervention(s) that will significantly diminish the targeted behaviors:
    - A specific plan of intervention for each of the targeted behaviors or symptoms identified in the assessment and the client plan, which is developed with the family/caregiver, if available, and as appropriate.
    - A specific description of the changes in the behaviors that the interventions are intended to produce, including an estimated time frame for these changes.
    - A specific way to measure the effectiveness of the intervention at regular intervals and documentation of refining the intervention plan when the original interventions are not achieving expected results.
- Transition Plan: A transition plan that describes the method the treatment team will use to decide how and when TBS will be decreased and ultimately discontinued, either when the identified benchmarks have been reached or when reasonable progress towards goals/benchmarks is not occurring and, in the clinical judgment of the treatment team developing the plan, are not reasonably expected to be achieved. This plan should address assisting parents/caregivers/school personnel with skills and strategies to provide continuity of care when TBS is discontinued.
- Transitional Age Youth: As necessary, includes a plan for transition to adult services when

[25] https://www.dhcs.ca.gov/formsandpubs/MHArchiveLtrs/MH-Ltr99-03.pdf
[26] https://www.dhcs.ca.gov/services/MH/Pages/Specialty_Mental_Health_Services.aspx

the individual is no longer eligible for TBS and will need continued services. This plan addresses assisting parents/caregivers with skills and strategies to provide continuity of care when this service is discontinued, when appropriate in the individual case. If the individual is between 18 and 21 years of age, include notes regarding any special considerations that should be taken into account.

- Signature: A signature (or electronic equivalent) of, at least, one of the following:
    - A clinician who developed the care plan or is providing the service(s) (If the above person providing the service is not licensed or waivered, a co-signature from a physician, licensed/waivered psychologist, licensed/registered social worker, or a licensed or registered marriage and family therapist is required).
    - A clinician representing the MHP providing the service.
    - If the above person providing the service is not licensed or waivered, a co-signature from a physician, licensed/waivered psychologist, licensed/registered social worker, or a licensed or registered marriage and family therapist is required.
- Evidence of the child/youth's degree of participation and agreement with the client plan as evidenced by the child/youth's or legal guardian's signature. If child/youth or legal guardian is unavailable or refuses to sign the client plan, a written explanation in the progress notes why the signature could not be obtained.
- Evidence that a copy of the Client Plan was provided to the child/youth or parent/caregiver upon request.
- TBS Client Plan updates should document the following: any significant changes in the child or youth's environment since the initial TBS Client Plan, and if TBS interventions tried to-date have not been effective and the child/youth is not making progress as expected towards identified goals. In this situation, there must be documentation indicating that the provider has considered alternatives and only requested additional hours/days for TBS based on the documented expectation that the additional time will be effective. A TBS Client Plan update is an addendum to the initial TBS Client Plan and is not a progress note.

Care Coordination

In previous sections, we explored SDOH and how access to resources contributes meaningfully to quality of life. Access to health care is an important driver of quality of life and health outcomes, and one that we can directly impact. We know far too well that accessing and navigating health care systems can be a challenge for anyone. This may be especially true in behavioral health because care can involve treatment providers across multiple disciplines and organizations. Appropriate access to health care requires not only that services be available and accessible at the time the person needs the services, but also that care is coordinated, streamlined, and non-duplicative, even when it is provided by multiple entities. Care that is not coordinated runs the risk of being ineffective, wasteful of health care resources, and onerous for the individuals it is designed to help. By coordinating their efforts, disparate care providers can function as a cohesive team, ensuring that the individual in care remains the focal point and has a significant role in their own treatment.

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

treatment.

Care coordination also meets federal requirements designed to ensure that each individual in care has an ongoing source of care appropriate to their needs. One person or entity must be formally designated as primarily responsible for coordinating the services accessed by the individual in care, and the individual in care must be provided information on how to contact their designated person or entity.[27] The Care Coordinator may be you, a treatment team member from your organization, or a treatment provider from another organization or delivery system. This role may have different names within various organizations, such as case manager, care manager, team facilitator, or the function of care coordination may be incorporated into the role of a clinician or other staff.

The main goal of the Care Coordinator is to meet the person's care needs by using treatment information in a deliberate way and sharing necessary information with providers and the individual in care, to guide the delivery of appropriate and effective care. Care Coordinators work to build teams and facilitate partnerships, creating formal and informal networks of support that enhance treatment for individuals in care and allow for sustainable support long after treatment ends. Care coordination serves as a key element of service planning, ensuring that treatment across the team is meeting the needs of the person in care, that plans are updated as needed and that barriers to success are overcome. Within the team, communication is a key element of success, along with empowering the individual in care to guide the team to meet their own needs. When referring or transitioning an individual in care, the provider should discuss the reason for referral or transition and ensure the individual understands, not only the reason for referral or transition, but also the expected outcome of the referral or transition. When transitioning care between MHP and MCP providers, be aware that DHCS has launched a Transition of Care Tool to assist with care coordination and communication during transitions.[28]

Treatment

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

Service Categories

Medi-Cal SMHS are comprised of a variety of treatment services provided to individuals, groups and/or families.

Definitions of some of the primary service types are below:[29]

"Member" and "Beneficiary" means the person who is eligible to receive Medi-Cal benefits.

Additionally, please note that "Collateral" is no longer a distinct service type. When documenting services provided to a collateral contact, providers should select the service code that best

[27] 42 CFR §438.208
[28] DHCS Behavioral Health Information Notice (BHIN) No: 25-020
[29] https://www.dhcs.ca.gov/SPA/Documents/Supp-2-to-Attachment-3-1-B.pdf

describes the activity performed.

Assessment: A service activity designed to collect information and evaluate the current status of a beneficiary's mental, emotional, or behavioral health to determine whether Rehabilitative Mental Health Services are medically necessary and to recommend or update a course of treatment for that beneficiary. Assessments shall be conducted and documented in accordance with applicable State and Federal statues, regulations, and standards

Crisis Intervention: An unplanned, expedited service, to or on behalf of a beneficiary to address a condition that requires more timely response than a regularly scheduled visit. Crisis intervention is an emergency response service enabling a beneficiary to cope with a crisis, while assisting the beneficiary in regaining their status as a functioning community member. The goal of crisis intervention is to stabilize an immediate crisis within a community or clinical treatment setting. Crisis intervention may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the beneficiary.

Crisis Stabilization: An unplanned, expedited service lasting less than 24 hours, to or on behalf of a beneficiary to address an urgent condition requiring immediate attention that cannot be adequately or safely addressed in a community setting. The goal of crisis stabilization is to avoid the need for inpatient services which, if the condition and symptoms are not treated, present an imminent threat to the beneficiary or others, or substantially increase the risk of the beneficiary becoming gravely disabled.

Intensive Care Coordination: ICC is a form of targeted case management service that facilitates assessment of care planning for, and coordination of services to members under the age of 21 who are eligible for full-scope Medi-Cal services and who meet medical necessity criteria for this service. ICC service components include assessing, coordination of services planning and implementation, monitoring and adapting, and transition. ICC services are provided through the principles of the Integrated Core Practice Model (ICPM), including the establishment of the Child and Family Team (CFT) to ensure facilitation of a collaborative relationship among a child or youth, their family, and are involved in multiple child-serving systems.[30] A key element of ICC is the establishment of an ICC coordinator, who often is a MHP employee or contractor.

Intensive Home-Based Services (IHBS): IHBS are individualized, strength-based interventions designed to correct or ameliorate mental health conditions that interfere with a child or youth's functioning and are aimed at helping the child or youth build skills necessary for successful functioning in the home and community, and improving the child's or youth's family's ability to help the child or youth successfully function in the home and community. IHBS services are provided according to an individualized treatment plan developed in accordance with the ICPM by the CFT in coordination with the family's overall service plan. IHBS activities support the engagement and participation of the child/youth and his/her /their significant support people. They may include but are not limited to assessment, plan development, therapy, and rehabilitation. IHBS is provided to members under age of 21 who are eligible[31] for full-scope Medi-Cal services and who meet medical necessity criteria.[32]

Medi-Cal Peer Support Services: Culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self advocacy, development of natural supports, and identification of strengths through structured activities

[30] Attachment 2, Section J of the Mental Health Contract Template
[31] https://www.dhcs.ca.gov/services/MH/Pages/Specialty_Mental_Health_Services.aspx
[32] Exhibit E – Attachment 2, Section K of the Mental Health Contract Template

such as group and individual coaching to set recovery goals and identify steps to reach the goals. Services aim to prevent relapse, empower beneficiaries through strength-based coaching, support linkages to community resources, and to educate beneficiaries and their families about their conditions and the process of recovery. Peer support services may be provided with the beneficiary or significant support person(s) and may be provided in a clinical or non-clinical setting. Peer support services can include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the beneficiary by supporting the achievement of the beneficiary's treatment goals.

Peer support services are based on an approved plan of care and may be delivered as a standalone service. Peer support services include one or more of the following service components:

> **Educational Skill Building Groups** means providing a supportive environment in which beneficiaries and their families learn coping mechanisms and problem-solving skills in order to help the beneficiaries achieve desired outcomes. These groups promote skill building for the beneficiaries in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.
>
> **Engagement** means Peer Support Specialist led activities and coaching to encourage and support beneficiaries to participate in behavioral health treatment. Engagement may include supporting beneficiaries in their transitions and supporting beneficiaries in developing their own recovery goals and processes.
>
> **Therapeutic Activity** means a structured non-clinical activity provided by a Peer Support Specialist to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the beneficiary's treatment to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the beneficiary; promotion of self-advocacy; resource navigation; and collaboration with the beneficiaries and others providing care or support to the beneficiary, family members, or significant support persons.

Medication Support Services: Include prescribing, administering, dispensing and monitoring drug interactions and contraindications of psychiatric medications or biologicals that are necessary to alleviate the suffering and symptoms of behavioral health conditions. This service may also include assessing the appropriateness of reducing medication usage when clinically indicated. Medication support services may include prescription, dispensing, monitoring, or administration of medication related to substance use disorder services for members with a co-occurring mental health condition and substance use disorder. Medication support services may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the member.

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

Mobile crisis services include warm handoffs to appropriate settings and providers when the

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

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

Psychosocial Rehabilitation: A recovery or resiliency focused service activity which addresses a mental health need. This service activity provides assistance in restoring, improving, and/or preserving a member's functional, social, communication, or daily living skills to enhance self-sufficiency or self-regulation in multiple life domains relevant to the developmental age and needs of the member. Psychosocial rehabilitation includes assisting members to develop coping skills by using a group process to provide peer interaction and feedback in developing problem-solving strategies. In addition, psychosocial rehabilitation includes therapeutic interventions that utilize self-expression such as art, recreation, dance or music as a modality to develop or enhance skills. These therapeutic interventions assist the member in attaining or restoring skills which enhance community functioning including problem solving, organization of thoughts and materials, and verbalization of ideas and feelings. Psychosocial rehabilitation also includes support resources, medication education, and/or psychoeducation. Psychoeducation assists members to recognize the symptoms of their mental health condition to prevent, manage or reduce such symptoms. Psychosocial rehabilitation, including psychoeducation, may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment needs of the member. Psychosocial rehabilitation may be provided to a member or a group of members.

Targeted Case Management (Case Management/Brokerage/Linkage): Services that assist an individual in care to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure access to service and the service delivery system; monitoring of individual progress.

Therapeutic Behavioral Services (TBS): Specialty mental health services covered as EPSDT services.[33] TBS are intensive, one-to-one, short-term outpatient services for members, under the age of 21 with full scope Medi-Cal, designed to help members and their parents/caregivers, foster parents, group home staff, and school staff manage specific behaviors using short-term

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

measurable goals based on the **child or youth's** needs.[34] Individuals receiving these services have serious emotional disturbances (SED), are experiencing a stressful transition or life crisis and need additional short-term, specific support services to achieve outcomes specified in their client plans. TBS is never a stand-alone therapeutic intervention; it is used in conjunction with another SMHS.

Therapeutic Foster Care (TFC): This model allows for the provision of short-term, intensive, highly coordinated, trauma informed and individualized specialty mental health services (SMHS) activities to children and under the age 21 who have complex emotional and behavioral needs and who are placed with trained, intensely supervised and supported by TFC parents. The TFC parent serves as a key participant in the therapeutic treatment process of the child or youth. TFC is intended for children and youth who require intensive and frequent mental health support in a family environment. Due to the nature of TFC, children who receive TFC will also benefit from other medically necessary SMHS and TFC should not be the only SMHS that a child or youth receives. Children and youth receiving TFC would also benefit from receiving ICC because the CFT would guide and plan the TFC service provision. The TFC service model allows for the provision of certain SMHS activities (plan development and rehabilitation) available under the EPSDT benefit as a home-based alternative to high level care in institutional settings such as group homes and an alternative to Short Term Residential Therapeutic Programs (STRTPs).[35]

Therapy: A service activity that is a therapeutic intervention that focuses primarily on symptom reduction and restoration of functioning to improve coping and adaptation and reduce functional impairments. Therapeutic intervention includes the application of cognitive, affective, verbal or nonverbal, strategies based on the principles of development, wellness, adjustment to impairment, recovery and resiliency to assist a beneficiary in acquiring greater personal, interpersonal and community functioning or to modify feelings, thought processes, conditions, attitudes or behaviors which are emotionally, intellectually, or socially ineffective. These interventions and techniques are specifically implemented in the context of a professional clinical relationship.

Co-Occurring Treatment

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

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

The No Wrong Door policy aims to ensure that members have access to the right care at the right time.[36] No Wrong Door specifies that clinically appropriate SMHS are covered and reimbursable whether the individual in care has a co-occurring SUD, without delay and regardless of the delivery system where they seek care. Similarly, clinically appropriate and covered DMC and DMC-ODS services are covered by DMC and DMC-ODS whether the

[34] Exhibit A-Attachment 2, Section L of the Mental Health Contract Template
[35] Exhibit E-Attachment 2, Section M of the Mental Health Contract Template
[36] DHCS Behavioral Health Information Notice (BHIN) No: 22-011

individual in care has a co-occurring mental health disorder. Co-occurring diagnoses can interact and influence each other, leading to more complex treatment. By recognizing and understanding the interplay between co-occurring diagnoses, providers can provide more effective treatment tailored to the individual's needs.

Progress Notes

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

Progress notes have multiple functions. First and foremost, progress notes are used to document the treatment that has occurred (the intervention), and the intended next steps (the plan). Progress notes can also serve as communication tools to alert other providers (or the individual in care themselves) of the status of treatment. For these reasons, each progress note should be understandable when read independently of other progress notes, providing an accurate picture of the individual's condition, treatment provided, and response to care at the time the service was provided. To facilitate clear and accurate communication, abbreviations should be avoided, unless universally recognized, so that they will be accessible to a range of providers with whom you may wish to coordinate care. Keep in mind that progress notes can be used in legal proceedings and may also be accessed by the individual in care themselves. Individuals should be able to recognize the treatment described; therefore, it is recommended that clinical or programmatic jargon be avoided.

Providers shall create progress notes for the provision of all Medi-Cal behavioral health delivery system services. Each progress note shall provide sufficient detail to support the service code(s) selected for the service type(s) as indicated by the service code description(s).[37] Should more than one provider render a service, either to a single member or to a group, at least one progress note per member must be completed. The note must be signed by at least one provider. The progress note shall clearly document the specific involvement and duration of direct patient care for each provider of the service.

Travel time and time spent documenting progress notes are no longer separately reimbursable; these activities are accounted for within provider reimbursement rates. It's important to continue to separately document travel and documentation time in progress notes as this data is essential for informing future rate-setting and ensuring an accurate representation of provider workloads.

Appendix V provides sample note narratives demonstrating sufficient documentation of interventions and next steps.

Required Progress Note Service Information[38]

- ☐ The type of service rendered.
- ☐ The date that the service was provided to the member.

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[37] For valid Medi-Cal claims, appropriate ICD-CM diagnostic codes, as well as HCPCS/CPT codes, must appear in the claim and must also be clearly associated with each encounter and consistent with the description in the progress note. However, current ICD-CM codes and HCPCS/CPT codes are not required to be included in the progress note narrative. For further guidance on use of ICD-10 codes during the assessment process, refer to BHIN 22-013.

[38] DHCS Behavioral Health Information Notice (BHIN) No: 23-068

- ☐ Duration of direct patient care for the service.[39]
- ☐ Location or place of service
- ☐ A typed or legibly printed name, signature of the service provider, and date of signature.
- ☐ A brief description of how the service addressed the member's behavioral health needs (e.g., symptom, condition, diagnosis, and/or risk factors).[40]
- ☐ A brief summary of next steps.[41]

Additional Requirements for Group Progress Notes

In addition to the progress note requirements above, group progress notes also require the following:

- ☐ When a group service is rendered, a list of participants is required to be documented and maintained by the provider (not to be included in the individual progress notes for each participant).
- ☐ Every participant shall have a progress note in their clinical record that documents the service encounter and their attendance in the group, and includes the information listed in above.
- ☐ The progress note for the group service encounter shall also include a brief description of the member's response to the service.

Progress Notes Timeliness

Documentation should be completed in a timely manner to support the provider's recall of the specifics of a service. Progress notes should never be completed in advance of a service. Below are timeliness expectations determined by DHCS:

Providers shall complete progress notes within three (3) business days of providing a service, with the exception of notes for crisis services, which shall be completed within one (1) calendar day. The day of the service shall be considered day zero (0).

A daily note is required for documentation of some residential services, day treatment, and other similar settings that use a daily rate for billing. In these programs, weekly summaries are no longer required.

If a note is submitted outside of the required timeframes, it is good practice to document the reason the note is delayed. Late notes remain billable and should not be withheld from the claiming process. Based on the program/facility type (e.g., STRTP DHCS regulations[42]), stricter

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[39] Direct patient care time is defined in the SMHS and DMC/DMC-ODS billings manuals; see https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx

[40] For example, as clinically indicated the brief description may include activities or interventions that occurred during the service event; issues discussed; and progress toward treatment goals or other treatment outcomes.

[41] For example, as clinically indicated next steps may include planned action steps by the provider or by the member; collaboration with the member; collaboration with other provider(s); goals and actions to address health, social, educational, and other services needed by the member; referrals; and discharge and continuing care planning.

[42] https://www.dhcs.ca.gov/Documents/STRTP-Regulations-version-II.pdf

note completion timelines may be required by state regulation.

While late progress notes do not lead to recoupments, timely documentation is essential for ensuring high-quality client care. Medi-Cal recoupments focus on fraud, waste, and abuse within service provision and claims and will only occur when clear evidence of these issues is present. Nonetheless, timely documentation supports overall care quality and compliance.[43]

Claiming for Services

Code Sets for Claiming Services

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

- **DSM Diagnosis:** Captures clinical information about the person's behavioral health needs and other conditions (clusters of symptoms) based on the current version of the DSM. The selection of appropriate treatment interventions is informed by the diagnosis, assessed need and problem list.
- **International Classification of Diseases - Clinical Modification (ICD-10-CM) Codes:** Captures detailed information about the disorder (granular information) and is used in claiming. The ICD is a standard transaction code set for diagnostic purposes under the Health Insurance Portability and Accountability Act (HIPAA).

Current Procedural Terminology and Healthcare Common Procedure Coding System Codes: These codes are used to capture uniform information for claiming for medical services and products. SMHS use a combination of Healthcare Common Procedure Coding System (HCPCS) codes and Current Procedural Terminology (CPT) codes to bill Medi-Cal. Please see Appendix VI for a list of commonly used HCPCS/CPT codes by provider type.

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

Care Transitions

Care transitions are the process of moving individuals in care between different health care settings or providers. These transitions are crucial periods where effective communication and coordination are essential to ensure continuity of care, prevent gaps, and avoid potential complications. In the context of whole person care, which focuses on addressing all aspects of an individual's health and social needs, care transitions are integral. They ensure that all providers are informed and that care plans are consistently followed. By prioritizing smooth care transitions, whole person care aims to improve overall health outcomes and enhance the quality of life for individuals in care.

Transition of Care Tool

The DHCS Transition of Care Tool ensures smooth and coordinated transitions when individuals in care start receiving additional NSMHS from MCPs or when they transition their

[43] Fraud and abuse are defined in Code of Federal Regulations, Title 42, § 455.2 and W&I Code, section 14107.11, subdivision (d). Definitions for "fraud," "waste," and "abuse" can also be found in the Medicare Managed Care Manual.

mental health care needs fully from the MHP to the MCP (or vice versa). The Transition of Care Tool provides valuable information about the individual in care to health care providers to allow for clinically meaningful continuity of care. The Transition of Care Tool is designed to be for all individuals in care, adults and youth alike. The decision to add or transition services from the MHP to the MCP must be made by an LPHA.[44] However, once the decision has been made, a non-clinician such as an administrative staff, peer support staff, or other professional who does not meet the definition for clinician may complete the Transition of Care Tool. The Transition of Care Tool can be completed in person, by telephone or by video conference with engagement from the individual in care throughout the process.

The Transition of Care Tool includes specific fields to document the following elements:

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

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

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

Discharge Planning

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

Discharge planning must include the individual in care and their social support as full partners in the planning process and should be done as far in advance as practical. If the individual in care is being discharged to a different kind of treatment, including other treatment providers, the discharge process can help the transition from one setting to another. Detailed information on

[44] DHCS Behavioral Health Information Notice (BHIN) No: 25-020

discharge planning should be clear, concise, and accurately communicated and documented.

A successful discharge discussion includes a review of how the individual can continue to receive any necessary support and how those needs may be addressed post-discharge from the program. Information contained in discharge plans and shared with the individual in care includes how the person's needs may be addressed, information on prescribed medications, the type of care the individual is expected to receive and by whom, information on crisis supports, and available community services, to name a few. Additionally, providers who work with individuals ages 6 through 20 are required to complete the CANS at discharge as well as a PSC-35 for individuals who are ages 3 through 18.[45]

Conclusion

This documentation guide is designed to support both new and experienced clinicians who are navigating the intricacies of California's behavioral health plans and the Medi-Cal system and providing effective clinical care that aligns with all applicable regulations. Whether you are just beginning your journey as a mental health staff or have years of experience, our goal is to provide a resource that equips you with the knowledge and tools to deliver high-quality, - person-centered care across every stage of service delivery.

For seasoned clinicians, this guide may reinforce and refine existing practices, offering updated perspectives and aligning your work with the latest developments in Medi-Cal transformation. For newer clinicians, it serves as a critical foundation upon which to build a career of effective and compassionate client care.

While accurate documentation is a vital part of this process, the broader purpose of this guide is to foster an integrated, thoughtful approach to behavioral health care that benefits mental health staff providing services to Medi-Cal members across California.

As you engage with the assessment, planning, and service delivery processes, remember that each component plays a role in improving outcomes and contributing to a more cohesive system of care. We encourage you to use this guide as an ongoing resource, whether to refresh your knowledge or to stay up to date on best practices.

Thank you for your dedication to providing high-quality care to the members you serve.

If you need further assistance or have feedback, please reach out to: managedcare@calmhsa.org

[45] DHCS Behavioral Health Information Notice (BHIN) No: 18-048

Appendix I: Acronym List

- ACE: Adverse Childhood Experience
- ASAM: American Society of Addiction Medicine
- BHIN: Behavioral Health Information Notice
- BIPOC: Black, Indigenous and People of Color
- CalAIM: California Advancing and Innovating Medi-Cal
- CANS: Child and Adolescent Needs and Strengths
- CFT: Child and Family Team
- CMS: Centers for Medicare & Medicaid Services
- CPT: Current Procedural Terminology
- DHCS: Department of Health Care Services
- DMC: Drug Medi-Cal
- DMC-ODS: Drug Medi-Cal Organized Delivery System
- DSM-5: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
- EHR: Electronic Health Record
- EPSDT: Early & Periodic Screening, Diagnosis and Treatment
- HCPCS: Healthcare Common Procedure Coding System
- HIPAA: Health Insurance Portability and Accountability Act
- ICC: Intensive Care Coordination
- ICD-10: International Classification of Diseases, Tenth Revision
- ICPM: Integrated Core Practice Model
- IOP: Intensive Outpatient
- IHBS: Intensive Home-Based Services
- LGBTQ+: Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and all sexual and gender minority identities
- LOC: Level of Care
- LPHA: Licensed Practitioner of the Healing Arts
- MAT: Medication for Addiction Treatment
- MCO: Managed Care Organization
- MCP: Managed Care Plan
- MHP: Mental Health Plan
- MHRS: Mental Health Rehabilitative Specialists
- NSMHS: Non-Specialty Mental Health Services

- NTP: Narcotic Treatment Program
- ODF: Outpatient Drug Free Treatment Services
- PSC-35: Pediatric Symptom Checklist
- SDOH: Social Drivers of Health
- SMHS: Specialty Mental Health Services
- STRTP: Short Term Residential Therapeutic Program
- SUD: Substance Use Disorder
- TBS: Therapeutic Behavioral Services
- TCM: Targeted Case Management
- TFC: Therapeutic Foster Care

Appendix II: Medi-Cal Plans by Type

Medi-Cal Benefits		
System	Services	Service Definition
Mental Health Plan (MHP)	Specialty Mental Health Services (SMHS) — Carved out of overall Medi-Cal benefit within 1915b Waiver[46]	• SMHS includes the following[47]: • Inpatient Psychiatric Services • Outpatient services, including intensive and community-based services, such as individual therapy, family and group therapy, care planning and assessment • Rehabilitative skill-building services in individual and/or group settings • Targeted Case Management • Medication Support Services • Day Treatment Intensive or Rehabilitation • Crisis Intervention and Stabilization • Adult and Crisis Residential Treatment • Intensive Care Coordination • Therapeutic Foster Care • Intensive Home-Based Services • Therapeutic Behavioral Services • Peer Support Services • Mobile Crisis Services
Managed Care Plan (MCP)	Non-Specialty Mental Health Services (NSMHS) and Physical Health Care	NSMHS include the following: • Mental health evaluation and treatment, including individual, group and family psychotherapy • Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition • Outpatient services for purposes of monitoring drug therapy • Psychiatric consultation • Outpatient laboratory, drugs, supplies, and supplements • For SUD: Screening, Brief Intervention and Referral to Treatment (SBIRT) and Medication Assisted Treatment (MAT)

[46] https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM-1115-and-1915b-Waiver-Renewals.aspx

[47] https://www.dhcs.ca.gov/services/MH/Documents/PPQA Pages/Boilerplate_2017-2022_MHP_Contract-Exhibits_A_B_and_E.pdf

Medi-Cal Benefits Cont'd		
System	Services	Service Definition
County Drug Medi-Cal Organized Delivery System (DMC-ODS)	Substance Use Treatment Continuum of Care Modeled after ASAM Criteria	Continuum of Care modeled after the American Society of Addiction Medicine (ASAM) criteria[48] including: • Screening, Brief Intervention, Referral to Treatment and Early Intervention Services (ASAM Level 0.5) • Outpatient (ASAM Level 1) • Intensive Outpatient (ASAM Level 2.1) • Partial Hospitalization (ASAM Level 2.5) • Residential Treatment (ASAM Levels 3.1, 3.3, 3.5) • Inpatient (ASAM Levels 3.7 and 4.0) (Medically Monitored or Medically Managed) • Narcotic Treatment Program • Withdrawal Management Services (ASAM Level 1-WM, Level 2-WM, Level 3.2-WM, Level 3.7-WM, Level 4-WM) • Medications for Addiction Treatment • Peer Support Services • Contingency Management • Recovery Services • Care Coordination • Clinician Consultation
Drug Medi-Cal (DMC)	Substance Use Treatment	Includes the following:[49] • Narcotic Treatment Program services • Outpatient Drug Free services • Day Care Habilitative services • Perinatal Residential Substance Use Disorder services • Naltrexone Treatment services • Mobile Crisis Services • Justice Involved Reentry Services

[48] ASAM LOC Criteria

[49] https://www.law.cornell.edu/regulations/california/22-CCR-51341.1

Appendix III: Scope of Practice Matrix

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

*Under the direct supervision of a Behavioral Health Professional
+ Training and certification requirement may apply
++ May require close supervision if issues of danger to self or others are present
+++ Typically limited to post-master's doctorate students
+* While other services may be technically allowable depending on an individual's classification, Certified Peer Specialists mainly utilize the Peer Support Service codes.
++++ The licensed physician, nurse practitioner, or physician assistant must be physically present in the facility during the provision of services by a medical assistant

Appendix IV: DHCS Priority SDOH Codes & All Z Codes

Please click here for the complete list of ICD-10-CM Z Codes

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

Z63.72	Alcoholism and drug addiction in family

Code	Description
Z64.0	Problems related to unwanted pregnancy*
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.4	Victim of crime and terrorism*
Z65.5	Exposure to disaster, war and other hostilities*

*Indicates codes that are not listed on the DHCS Priority SDOH Codes list

Appendix V: Sample Progress Notes

Progress notes should capture essential information that supports service delivery but do not need to include unnecessary detail. Generally speaking, the contents of the progress note shall support the service code(s) selected and support effective clinical care and coordination among providers. Notes shall include the minimum elements described in the Progress Notes section of this guide, but the nature and extent of the information included may vary based on the service type and the member's clinical needs. Some notes may appropriately contain less descriptive detail than others. If information is located elsewhere in the clinical record (for example, a treatment plan template), it does not need to be duplicated in the progress note.

There are no established guidelines dictating how a progress note writer should refer to themselves or the client, as this may vary based on personal style or common practices within a given organization.

Note: Certain service types billable to other insurance providers, including Medicare, may necessitate additional documentation detail. It is essential to consult with your county to confirm whether enhanced documentation is required for these services.

Assessments

90791 Psychiatric Diagnostic Evaluation

Therapist met with the client today in order to conduct an assessment based upon presenting concerns that include heighted anxiety, persistent depression, and difficulty sleeping for the past 6 months. Client's symptoms have impacted his functioning, leading to issues at work and strained social relationships. Based on the clinical assessment, client meets criteria for Generalized Anxiety Disorder (F41.1) and Major Depressive Disorder, Single Episode, Moderate (F32.1).

Client will be referred to psychiatry for a medication evaluation and individual therapy.

90792 Psychiatric Diagnostic Evaluation with Medical Assessment

Psychiatrist met with the client today in order to conduct a psychiatric evaluation based on presenting concerns that include increased irritability, mood swings, and difficulty concentrating over the past 4 months. The client reports frequent headaches, changes in appetite, and persistent fatigue, which have significantly impacted work performance and strained personal relationships. Client's symptoms have affected daily functioning, leading to poor focus at work and conflicts in social settings. Based on the clinical assessment, client meets criteria for Bipolar II Disorder (F31.81) and Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Presentation (F90.0).

Client will receive ongoing medication management as well as individual therapy and case management.

Crisis Intervention

H2011 Crisis Intervention Services

Therapist met with client today for crisis intervention due to acute emotional distress triggered by family conflict and job-related stress. Crisis de-escalation techniques, including grounding exercises and guided deep breathing, were utilized to help stabilize the client's emotional state and reduce immediate distress. A safety plan was collaboratively developed, including identification of supportive contacts and coping strategies to manage potential future crises.

Therapist will follow up with the client later this week to assess the effectiveness of the safety plan, review coping strategies, and evaluate whether additional supports or interventions are necessary.

Rehabilitation
H2017 Psychological Rehabilitation

I met with client today to provide psychological rehabilitation services based on concerns related to functional impairments that include inability to maintain employment given intense feelings of anxiety. I focused on providing psychoeducation and building skills related to emotion regulation and managing chronic stress in order to increase client's functioning in social and occupational settings — specifically, we discussed mindfulness techniques and reframing stressful situations.

When we meet next week, we will discuss the client's perspective on how helpful these coping skills have been and will continue to explore strategies that can assist the client with effectively managing symptoms of anxiety.

Individual Therapy
90837 Individual Psychotherapy

Therapist met with client for individual therapy to address symptoms related to PTSD, including hypervigilance, intrusive thoughts, and emotional dysregulation. During the session, the therapist utilized Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) to help the client identify and reframe distorted thoughts contributing to emotional distress. Grounding exercises were introduced to assist the client in managing acute emotional reactions and increasing present-moment awareness during moments of distress.

I will meet with the client again next week for our scheduled therapy session where we will continue to utilize TF-CBT techniques to assist the client with managing ongoing emotional distress. In upcoming sessions, additional TF-CBT interventions, including further cognitive restructuring and exposure work, will be introduced to support continued progress.

Family Therapy
90847 Family Psychotherapy [Conjoint Psychotherapy] (with Patient Present)

Clinician met with the client and family members today for family therapy to address relational issues exacerbated by the client's symptoms of bipolar disorder, including mood swings and impulsivity. The session focused on helping the family understand how these symptoms impact communication and contribute to ongoing conflict. Clinician provided psychoeducation on dipolar Disorder to improve the family's understanding of the client's behavior and taught strategies for managing conflict, including active listening and de-escalation techniques. The family agreed to practice these skills between sessions and monitor how the client's symptoms affect their interactions.

Clinician will continue holding family therapy sessions monthly to support the family in navigating challenges related to the client's symptoms and to reinforce effective communication and conflict resolution skills.

Group Therapy
90853 Group Psychotherapy

Clinician facilitated a group psychotherapy session today for individuals diagnosed with

generalized anxiety disorder (GAD), focusing on stress management and emotional regulation. Clinician introduced coping strategies, including mindfulness and deep breathing exercises, specifically tailored to help manage the excessive worry and tension commonly experienced by individuals with GAD. Clinician encouraged ongoing peer support outside of the group to reinforce the strategies discussed in today's session.

Clinician will schedule a follow-up group session to introduce additional anxiety management tools and to continue to assist the client in effectively using these tools in daily life.

Targeted Case Management
T1017 Targeted Case Management

This staff contacted the local county community center to inquire about programs that could assist with addressing the client's mental health needs. After discussing the types of programs that could be beneficial for the client, the community center staff confirmed that the center's wellness group and social support activities would be appropriate. This staff requested information about next steps for the client to enroll and participate in upcoming sessions.

This staff will contact the client to explain the available resources, assist with the enrollment process, and prepare the client for potential participation in these programs.

Medication Support Services
Medication Support (E/M – Prescriber)

The psychiatrist met with the client and consulted with the client's clinician. The client has a significant trauma history, likely contributing to current issues, including persistent sleep disturbances despite some benefit from melatonin. He is waking frequently during the night and struggles to return to sleep, which, along with social difficulties, raises concerns about potential sleep apnea impacting mood and irritability. A sleep study has been completed, and results are pending. Notably, the client's behaviors and anger have significantly improved since starting treatment. Vital signs on 6/1/2020 and 7/17/2020: Height 4'6.5," Weight 123 lb./45.4 kg, BP 118/70, 110/77, Pulse 97, 95. The mental status exam was within normal limits, and the client reportedly adheres to the medication regimen without side effects.

The plan is to continue melatonin 5 mg QHS, with a follow-up session scheduled in 4 weeks to discuss medication effectiveness and overall symptom management.

Medication Support (Non-Prescriber)

Writer met with youth to collect vital signs and discuss upcoming psychiatry appointment. Collected vital signs, height and weight. Reviewed name, dosage and purpose of each medication in the current regimen. Inquired as to any side effects or concerns. Encouraged youth to share any concern he may have during psychiatry appointment this week with Dr. Smith. Engaged youth in discussion on importance of eating regularly and staying hydrated. Inquired as to any health concerns. None reported.

Writer will meet with client again next month prior to their psychiatry appointment.

Peer Support
H0038 Self-help/Peer Services

Peer Specialist met with the client today to provide peer support services aimed at addressing

the client's ongoing symptoms of severe depression, characterized by persistent feelings of hopelessness and difficulty engaging in daily activities. The Peer Specialist facilitated a discussion about the client's challenges and shared personal experiences to offer support and foster connection. Coping strategies that have been effective in similar situations were shared, including mindfulness techniques and structured daily routines.

A follow-up session is scheduled for next week to monitor the client's progress and process strategies that can effectively address symptoms of depression.

H0025 Behavioral Health Prevention Education Services (delivery of services with target population to affect knowledge, attitude, and/or behavior)

Peer Specialist met with the client today to provide prevention education services aimed at reducing the risk of substance use and increasing awareness of its long-term effects on mental health. The Peer Specialist discussed the physical, psychological, and social consequences of substance use with the client. Over the next week, the client will reflect on their personal experiences with substance use and identify its impacts on their functioning.

A follow-up session will be scheduled to explore prevention strategies further and track any behavioral changes.

Plan Development
Mental Health Service Plan Developed by Non- Physician, 15 Minutes

The MHRS has completed a treatment plan outlining specific goals and interventions to address the client's symptoms of schizoaffective disorder.

I will continue meeting with the client weekly to implement the treatment plan, monitor progress, and adjust interventions as needed to ensure ongoing support for the client's mental health needs.

Appendix VI: Commonly Used Service Codes

The table below identifies commonly used service codes, and the disciplines allowed to bill each code. This list of codes is not comprehensive. Every county's implementation of service codes in their EHR is different. For example, some EHRs use the code description set by CMS, whereas others use simplified code descriptions. For additional information on service codes, please refer to the CalMHSA CPT for Direct Service Providers learning management system training here.

Assessment		
Code	CMS Code Description	Allowable Discipline
90791	Psychiatric Diagnostic Evaluation, 15 Minutes	CNS, CNS-CT, LCSW, LCSW-CT, LMFT, LMFT-CT, LPCC, LPCC-CT, MD/DO, MD/DO-Clerks, NP, NP-CT, PA, PA-CT, PhD-CT/PsyD-CT, PhD/PsyD
90792	Psychiatric Diagnostic Evaluation with Medical Assessment	CNS, CNS-CT, MD/DO, MD/DO-Clerks, NP, NP-CT, PA, PA-CT
90885	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes	CNS, CNS-CT, LCSW, LCSW-CT, LMFT, LMFT-CT, LPCC, LPCC-CT, MD/DO, MD/DO-Clerks, NP, NP-CT, PA, PA-CT, PhD-CT/PsyD-CT, PhD/PsyD
96130	Psychological Testing Evaluation, First Hour	CNS, CNS-CT, MD/DO, MD/DO-Clerks, NP, NP-CT, PA, PA-CT, PhD-CT/PsyD-CT, PhD/PsyD
H0031	Mental Health Assessment by Non-Physician, 15 Minutes	AOD, CNS, CNS-CT, LCSW, LCSW-CT, LMFT, LMFT-CT, LOT, LOT-CT, LPCC, LPCC-CT, LPT, LPT-CT, LVN, LVN-CT, MHRS, NP, NP-CT, Other, PA, PA-CT, PhD-CT/PsyD-CT, PhD/PsyD, Pharm, Pharm-CT, RN, RN-CT
Crisis Intervention		
Code	CMS Code Description	Allowable Discipline
90839	Psychotherapy for Crisis, First 30-74 Minutes	CNS, CNS-CT, LCSW, LCSW-CT, LMFT, LMFT-CT, LPCC, LPCC-CT, MD/DO, MD/DO-Clerks, NP, NP-CT, PA, PA-CT, PhD-CT/PsyD-CT, PhD/PsyD
H2011	Crisis Intervention Services, per 15 minutes	AOD, CNS, CNS-CT, LCSW, LCSW-CT, LMFT, LMFT-CT, LOT, LOT-CT, LPCC, LPCC-CT, LPT, LPT-CT, LVN, LVN-CT, MD/DO, MD/DO-Clerks, MHRS, NP, NP-CT, Other, PA, PA-CT, PhD-CT/PsyD-CT, PhD/PsyD, Pharm, Pharm-CT, RN, RN-CT

Community-Based Mobile Crisis Intervention Services		
Code	CMS Code Description	Allowable Discipline
H2011	Mobile Crisis	Not applicable
Rehabilitation		
Code	CMS Code Description	Allowable Discipline
H2017	Psychosocial Rehabilitation, per 15 Minutes	CNS, CNS-CT, LCSW, LCSW-CT, LMFT, LMFT-CT, LOT, LOT-CT, LPCC, LPCC-CT, LPT, LPT-CT, LVN, LVN-CT, MA, MD/DO, MD/DO-Clerks, MHRS, NP, NP-CT, Other, PA, PA-CT, PhD-CT/PsyD-CT, PhD/PsyD, Pharm, Pharm-CT, RN, RN-CT
H2021	Community-Based Wrap-Around Services, per 15 minutes	AOD, CNS, CNS-CT, LCSW, LCSW-CT, LMFT, LMFT-CT, LOT, LOT-CT, LPCC, LPCC-CT, LPT, LPT-CT, LVN, LVN-CT, MA, MD/DO, MD/DO-Clerks, MHRS, NP, NP-CT, Other, PA, PA-CT, PhD-CT/PsyD-CT, PhD/PsyD, Pharm, Pharm-CT, RN, RN-CT
Therapy		
Code	CMS Code Description	Allowable Discipline
90832	Psychotherapy, 30 Minutes with Patient	CNS, CNS-CT, LCSW, LCSW-CT, LMFT, LMFT-CT, LPCC, LPCC-CT, MD/DO, MD/DO-Clerks, NP, NP-CT, PA, PA-CT, PhD-CT/PsyD-CT, PhD/PsyD
90834	Psychotherapy, 45 Minutes with Patient	CNS, CNS-CT, LCSW, LCSW-CT, LMFT, LMFT-CT, LPCC, LPCC-CT, MD/DO, MD/DO-Clerks, NP, NP-CT, PA, PA-CT, PhD-CT/PsyD-CT, PhD/PsyD
90837	Psychotherapy, 60 Minutes with Patient	CNS, CNS-CT, LCSW, LCSW-CT, LMFT, LMFT-CT, LPCC, LPCC-CT, MD/DO, MD/DO-Clerks, NP, NP-CT, PA, PA-CT, PhD-CT/PsyD-CT, PhD/PsyD
90847	Family Psychotherapy [Conjoint Psychotherapy] (with Patient Present), 50 Minutes	CNS, CNS-CT, LCSW, LCSW-CT, LMFT, LMFT-CT, LPCC, LPCC-CT, MD/DO, MD/DO-Clerks, NP, NP-CT, PA, PA-CT, PhD-CT/PsyD-CT, PhD/PsyD
90849	Multiple-Family Group Psychotherapy, 15 Minutes	CNS, CNS-CT, LCSW, LCSW-CT, LMFT, LMFT-CT, LPCC, LPCC-CT, MD/DO, MD/DO-Clerks, NP, NP-CT, PA, PA-CT, PhD-CT/PsyD-CT, PhD/PsyD
90853	Group Psychotherapy (Other Than of a Multiple-Family Group), 15 Minutes	CNS, CNS-CT, LCSW, LCSW-CT, LMFT, LMFT-CT, LPCC, LPCC-CT, MD/DO, MD/DO-Clerks, NP, NP-CT, PA, PA-CT, PhD-CT/PsyD-CT, PhD/PsyD

Therapeutic Behavioral Services		
Code	CMS Code Description	Allowable Discipline
H2019	Therapeutic Behavioral Services, per 15 Minutes	AOD, CNS, CNS-CT, LCSW, LCSW-CT, LMFT, LMFT-CT, LOT, LOT-CT, LPCC, LPCC-CT, LPT, LPT-CT, LVN, LVN-CT, MA, MD/DO, MD/DO-Clerks, MHRS, NP, NP-CT, Other, PA, PA-CT, PhD-CT/PsyD-CT, PhD/PsyD, Pharm, Pharm-CT, RN, RN-CT
Peer Support Services		
Code	CMS Code Description	Allowable Discipline
H0038	Self-help/peer services per 15 minutes	Certified Peer Specialist
H0025	Behavioral health prevention education services (delivery of services with target population to affect knowledge, attitude, and/or behavior)	Certified Peer Specialist
Referral		
Code	CMS Code Description	Allowable Discipline
T1017	Targeted Case Management, Each 15 Minutes	AOD, CNS, CNS-CT, LCSW, LCSW-CT, LMFT, LMFT-CT, LOT, LOT-CT, LPCC, LPCC-CT, LPT, LPT-CT, LVN, LVN-CT, MA, MD/DO, MD/DO-Clerks, MHRS, NP, NP-CT, Other, PA, PA-CT, PhD-CT/PsyD-CT, PhD/PsyD, Pharm, Pharm-CT, RN, RN-CT
Plan Development		
Code	CMS Code Description	Allowable Discipline
H0032	Mental Health Service Plan Developed by Non- Physician, 15 Minutes	AOD, CNS, CNS-CT, LCSW, LCSW-CT, LMFT, LMFT-CT, LOT, LOT-CT, LPCC, LPCC-CT, LPT, LPT-CT, LVN, LVN-CT, MHRS, NP, NP-CT, Other, PA, PA-CT, PhD-CT/PsyD-CT, PhD/PsyD, Pharm, Pharm-CT, RN, RN-CT
99366	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, participation by non-physician. Face-to-face with patient and/or family, 30 minutes or more	CNS, CNS-CT, LCSW, LCSW-CT, LMFT, LMFT-CT, LPCC, LPCC-CT, MA, NP, NP-CT, PA, PA-CT, PhD-CT/PsyD-CT, PhD/PsyD, Pharm, Pharm-CT, RN, RN-CT
99368	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, participation by non-physician. Patient and/or family not present, 30 minutes or more	CNS, CNS-CT, LCSW, LCSW-CT, LMFT, LMFT-CT, LPCC, LPCC-CT, MA, NP, NP-CT, PA, PA-CT, PhD-CT/PsyD-CT, PhD/PsyD, Pharm, Pharm-CT, RN, RN-CT

Plan Development		
Code	CMS Code Description	Allowable Discipline
99484	Care Management Services for BH Conditions directed by physician, at least 20 minutes	CNS, CNS-CT, LCSW, LCSW-CT, LMFT, LMFT-CT, LPCC, LPCC-CT, LPT, LPT-CT, LVN, LVN-CT, MA, MD/DO, MD/DO-Clerks, NP, NP-CT, PA, PA-CT, PhD-CT/PsyD-CT, PhD/PsyD, Pharm, Pharm-CT, RN, RN-CT