County of San Bernardino
Department of Behavioral Health

Outpatient Chart Manual

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Introduction

Services

The Outpatient Chart Manual applies to all non-patient services whose medical records are governed by Medi-Cal requirements. This includes all of the Department's outpatient, day treatment, case management, and medication services.

Manual priority

This manual, rather than the **Department's Standard Practice Manual**, governs charting and record keeping in the Department.

Manual Maintenance

The Department's Quality Management (QM) division maintains the Manual. Revisions are issued periodically, and it is important to file them appropriately so that your Manual is up-to-date.

If you find things in the Manual that are not clear, or look for things in the Manual but cannot find them, please inform QM so that we can improve the Manual.

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OUTPATIENT CHART MANUAL

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Care Necessity Form

Purpose

The Care Necessity form provides documentation of the Departmental and programmatic reasons why an individual qualifies for Department services.

Procedure for Completion

The following procedure is followed when completing this form:

Step	Action
1	Complete the form upon admission during the intake period. **Note:** As of 4/03 there is no requirement for routine repeated completion of the form following the initial intake period.
2	Check all boxes that apply to the client, even if the client does not currently have the type of coverage implied.
3	Update the form as coverages change.
4	The form must be signed by an LPHA: • M.D. • Registered Nurse • Licensed or Waivered Psychologist • Licensed/Registered/Waivered Social Worker • Licensed/Registered/Waivered MFT **Note:** The form may be completed by Graduate Student "Interns", but requires co-signature of a fully licensed LPHA.

Client Resource Evaluation

Purpose

The Client Resource Evaluation is completed on the first or the second client visit to identify basic resource needs, so that efforts can be made immediately to help clients obtain needed resources.

Form completion

The following considerations are made when completing the **Client Resource Evaluation:**

- The client's sense of what his/her needs are is the basis of the evaluation (which includes what the client views as appropriate in his/her culture)
  - Staff may, however, identify needs that the client denies due to fear or psychopathology, even though the client refuses help with these needs at the time.
- In each section check "no need", or describe how the:
  - Need is currently being met;
  - Any additional need level, and
  - An initial plan for how to meet that need better.
- Obtain the client's signature on the form, if possible. The client may be given a copy of the completed form

Diagnosis

Requirement

A complete 5-axis DSM-4 diagnosis is required and must be:

- Written out in full with:
  - Code numbers
  - Diagnosis names
  - All applicable qualifiers

Additionally, the diagnosis must be:

- Consistent with
- Supported by
- Descriptive of the history and symptoms detailed in the **Clinical Assessment**

Initial Time Frame

The following time requirements apply to the diagnosis:

- No billing can be done without a diagnosis, so a diagnosis must be made on the first visit (including an initial medications visit), even if it is provisional
- This diagnosis must be entered on the blue diagnosis page dated before or on the date of the first billable service
- A physician or clinician may complete the initial diagnosis

Official diagnosis

The official diagnosis of a client is the diagnosis on the diagnosis "blue" sheet.

- Any clinician or physician wishing to change that diagnosis must make the change on that page, with appropriate coordination with other open charts for the client
  - (See **UNIFORMITY OF DIAGNOSIS IN MULTIPLE OPEN CHARTS** below.)

Important: A diagnosis entered in an **ID note** without a change of diagnosis on the diagnosis page is ***not*** an operative diagnosis

Axis IV

The client's specific psychosocial and environmental problems are:

- Written out, in descending order of severity
  - (The problem categories (e.g. "Problems with Primary Support Group") are not used on Axis IV in the chart)
- Not given a numerical rating on Axis IV
  - (The SIMON entry for Axis IV can be "J" for unknown or "A" through "I" for the categories of problems listed in **DSM-4**)

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Axis V

The following are requirements for Axis V:

- A current GAF is required on Axis V
- GAF ratings for other time periods may be added, at the clinician's discretion
  - (The SIMON entry for the second Axis V field is "00" for unknown or the numerical rating for "highest past year" functioning.)

Provisional and Rule-Out Diagnoses

Any provisional, deferred, or rule-out diagnoses must be clarified within 60 days after they are first given.

Deferred or V71.09 Diagnoses

The SIMON system will accept a deferred diagnosis (799.90) on either Axis I or Axis II (but not both) on opening an episode, but will not accept a deferred diagnosis on closing an episode.

"No diagnosis" (V71.09) will be accepted by SIMON on either Axis I or Axis II (but not on both), for opening and closing

<table>
<tr><th>If the true diagnosis is …</th><th>Then…</th></tr>
<tr><td>V71.09 on both Axis I and Axis II,</td><td>Enter these true diagnoses in the chart.</td></tr>
<tr><td></td><td><table>
<tr><th>If…</th><th>Then enter…</th></tr>
<tr><td>Opening in SIMON when the true diagnosis is V71.09 on both Axis I and I</td><td>Enter 799.9 on Axis I and V71.09 on Axis II.</td></tr>
<tr><td>Closing in SIMON when the true diagnosis is V71.09 on both Axis I and II,</td><td>Enter V71.9 on Axis I and V71.09 on Axis II.</td></tr>
</table></td></tr>
<tr><td colspan="2">SIMON staff will convert the V71.9 to V71.09.</td></tr>
</table>

Substance Use and Mental Retardation

The Department will not usually be reimbursed for treatment of persons with principal diagnoses of alcohol or drug problems or mental retardation, so some other mental disorder should be the principal or billing diagnosis. Substance use and mental retardation diagnoses can be appropriate secondary diagnoses.

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Ensuring that all Secondary Diagnoses are made

All applicable diagnoses **ARE** to be made (especially substance diagnoses), since this is the only way that our management information system can provide accurate information for program planning. Substance-related and mental retardation diagnoses should not be primary or billing diagnoses for mental health billing (although substance-related diagnoses are primary billing diagnoses for ADS).

Organic Mental Disorders

The following are considerations when charting the diagnosis of a client with an organic mental disorder:

- If organic mental disorders are treated, the treatment must be recognized and potentially effective mode of treatment for the aspects or sequelae of the organic disorder that are being treated (such as depression secondary to cognitive dysfunction)
- Add all appropriate Axis III entries needed in conjunction with an Organic Mental Disorder diagnosis

Co-Signature: staff authorized to diagnose

The diagnosis and any changes in diagnosis must be co-signed by a person qualified to diagnose, if the person completing the assessment is not so qualified. The following staff are the only ones authorized to co-sign:

- Licensed M.D.'s
- Licensed Clinical Therapists
- Licensed Clinic Supervisors
- Licensed Program Managers

Consistency of Diagnosis with medications

Physicians will ensure that the diagnosis on the blue Diagnosis sheet is consistent with medications being prescribed.

As of 8/21/02, there is no longer a requirement:

- For an Annual M.D. signature on the Diagnosis sheet
- That clients not receiving meds be reviewed annually

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Uniformity of Diagnosis in multiple open charts

All service sites must operate under a uniform diagnosis for any given client. This diagnosis will normally be the diagnosis in the chart that was opened first among the currently open chart (episodes) for that client. This concept is demonstrated by the following procedure:

Step	Action
1	When other sites open charts on a client, they will: • Obtain a copy of the **Diagnosis** sheet from the first opened chart (if there are other currently open charts), and • Will either use the diagnosis as is, or confer with the first opened clinic regarding any changes in diagnosis?
2	Discuss the situation with the first-opened clinic, if staff wishes later to change the diagnosis.
3	Reach diagnostic consensus with all provider sites so that there is a consistent diagnosis in all client charts at any given time.
4	Involve treatment teams in diagnostic discussions to reach consensus, if necessary.

Using the form and changing a diagnosis

The **Diagnosis** form is used in the following ways when changing a diagnosis:

- The form contains sections for two complete diagnoses. Any change in diagnosis requires re-writing the diagnosis in full, using either the second section on the form, or a new Diagnosis sheet with the same date and a signature below
- A “P” is placed in front of the code number of the principal diagnosis, if that principal diagnosis is not the first diagnosis on Axis I

Professional disagreement on diagnosis

Diagnoses may be changed by clinicians or by physicians, however the following guidelines must be adhered to:

- Consultation must occur regarding the most appropriate diagnoses
- Neither clinicians nor physicians should by implication invalidate the treatment that the other is providing by changing a diagnosis without consultation
- DSM-4 criteria will serve as the bases for diagnosis in all cases
- Diagnostic disagreements which cannot be resolved may be appealed in the chain of command, with final decision by the Chief of Medical services

Explanatory note

Changes in Axes I or II must be explained in a regular session note or in a separate ID note labeled “Diagnosis Change” on the same date as the diagnostic change.

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Annual update

There is no requirement for a scheduled diagnosis update. The diagnosis will be updated as needed in conformance with the client's condition.

Principal diagnoses which meet Medi-Cal medical necessity rules

Attachment 1 identifies those diagnoses that are acceptable as principal diagnoses in justifying treatment according to Medi-Cal's medical necessity criteria. (The other, "excluded" diagnoses may still be present as non-treated secondary diagnoses if an "included" diagnosis is the principal diagnosis.)

Diagnoses from other facilities

If it is necessary for a staff person who is not qualified to determine a diagnosis to open an episode with only in-the-field contact (no clinic visit), the episode may be opened using a copy of a written diagnosis made within the last 45 days by another reputable institution inpatient hospital, clinic, etc. The DBH Diagnosis sheet must be completed within the intake period by a person qualified to diagnose.

Included and Excluded DSM-4 Diagnoses for Medi-Cal Specialty Mental Health Services (Adults and Children) 3/98

Accepted/ Included diagnoses

The following is a listing of diagnoses accepted/included as principal diagnoses as the focus of treatment. **Note:** the listing of a DSM- 4 section below, such as Elimination Disorders, refers to all diagnoses in that section.

- Pervasive Developmental Disorders Except Autistic Disorder
- Attention-Deficit and Disruptive Behavior Disorders
- Feeding and Eating Disorders of Infancy and Early Childhood
- Elimination Disorders
- Other Disorders of Infancy, Childhood or Adolescence
- Schizophrenia and Other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Paraphilias
- Gender Identity Disorder
- Eating Disorders
- Impulse Control Disorders Not Elsewhere Classified
- Adjustment Disorders
- Personality Disorders (except Antisocial Personality Disorder)
- Medication-Induced Movement Disorders (if related to other included diagnoses)

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Included and Excluded DSM-4 Diagnoses for Medi-Cal Specialty Mental Health Services (Adults and Children) 3/98,
Continued

Not Accepted/ Excluded diagnoses

The following is a listing of diagnoses not accepted/excluded as principal diagnoses as the focus of treatment:

- Mental Retardation
- Learning Disorders
- Motor Skills Disorder
- Communication Disorders
- Autistic Disorder
- Tic Disorder
- Delirium, Dementia, and Amnestic and other Cognitive Disorders
- Mental Disorders Due to General Medical Condition Not Elsewhere Classified
- Substance-Related Disorders
- Sexual Dysfunctions
- Sleep Disorders
- Antisocial Personality Disorder
- Psychological Factors Affecting Medical Condition
- Adverse Effects of Medication NOS
- Relational Problems (V-Codes)
- Problems Related to abuse or Neglect (V-Codes and others)
- Additional Conditions That May be a Focus of Clinical Attention (V-Codes and others

Note

A client who has medical necessity may receive treatment for an included diagnosis even if the client also has an excluded diagnosis.

Initial Contact Form

Policy

The current, approved **Initial Contact Form** will be used by all DBH sties as the basic tool for gathering information from potential clients upon first contact.

Note: See the DBH SPM for procedures and all required forms for that initial contact.

Procedure for completion

The following procedure shall be followed when completing the **Initial Contact Form.**

If the potential client …	**Then the potential client may …**
Is able and cooperative,	Be asked to fill out the form on their own. Clerical staff may assist them in completing this form.
Unable to complete the form or refuses to do so,	Not be required to complete the form. The client's inability or refusal to complete the form will not be used as a reason not to evaluate the person.
Staff will gather only information needed for their own tasks, using or not using the form.	

Medical Necessity

Criteria

The Medi-Cal medical necessity criteria are printed in the Care Necessity form. Each client must be evaluated with regard to medical necessity when the client is first seen. Changes in medical necessity must be documented in the ID notes

Clients not meeting medical necessity

See current Department policy regarding whether any services may be provided to those who do not meet Medi-Cal medical necessity criteria.

Closing the Chart

Definition

A chart is “closed” when all services at that site are terminated.

Intake period closure

If a chart is closed within the initial two-month intake period, then the Clinical Assessment, Client Plan, and Discharge Summary do not need to be completed. (The Care Necessity form and Diagnosis sheet should be completed for every client if enough information has been gathered to enable completing these forms.)

Treatment delivered without these completed forms must be appropriately justified by the description in the chart of the client’s problems and medical necessity in the:

- ID notes and/or
- Partially completed Clinical Assessment

Charts with a recorded "no-show” after the intake period must have all of the usual paperwork elements mentioned above completed.

Timing of SIMON closures

Since open episodes are necessary for billing, episodes should not be closed in SIMON until all case billing has been completed.

Documentation

In all cases there will be:

- A closing ID note, noting the fact of the closure.

If the…	And…	Then…
Chart is closed during the intake period,	Discharge Summary form is not used,	This ID note will include the: • Reason for the client’s treatment • Course of treatment • Reason for discharge • Client’s condition on discharge
Chart is closed with only one service	There is no clinical discussion of the closure needed in the closing ID note	A clerk may write the closing ID note, but it must be co-signed by the Clinic Supervisor

Schedule of Essential Chart Forms and Due Dates

Introduction	The following documents are required in all client charts by the due dates noted.
Prior to any billing	Diagnosis sheet completed and dated before or on the date of the first billable service is required.
By the end of the first two months	The following documents are required: • Clinical Assessment • Care Necessity form • Diagnosis sheet (must be completed at the time of the first visit) • Outpatient Consent form • Advance Directives form • Client Resource Evaluation • Client Recovery Plan
In the 30 days following the start of a new service	Client Plan for that new service is required
In the 30 days before the end of every services period	A new (re-written) Client Plan for any continuing services is required.
As needed	The following documents are required as needed: • Update of Diagnosis sheet, when changes occur • Update of Clinical Assessment, when appropriate • Update of Care Necessity criteria, when appropriate • Update of Client Plan elements, when appropriate
Charts including medication(s)	For charts that include medication(s), include all of the above-mentioned documents as well as the following.

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Schedule of Essential Chart Forms and Due Dates, Continued

By the end of the first two months	Chart must include: • Medications Consent form (when medications are started) • Physical Assessment form • AIMS form
Annually In the first 30 days before the DOE anniversary date	Chart must include: • Update of Physical Assessment and AIMS forms • New Client Plan for MSS (unless not expiring because already done in last 12 months)
As needed	Chart must include the following as needed: • Update of Medications Consent form and client signature (when medications change) • Update of meds plan as appropriate in Client Plan • M.D. check diagnosis to ensure consistency with medications given

Time Period Definitions

Definitions

The following chart provides time period definitions used in charting.

Time Period Name	Definition
Date of Entry (DOE)	The date of opening of the episode. This is sometimes called the “date of registration”
Intake Period	The two-month period starting with the date of entry.

If the …	Then the…
Client’s date of entry is 2/15/95	End of the intake period is 4/14/95.
(For an entry date of 12/30 or 12/31, the end of the intake period is the last day of February)	

Annual Period	Exactly twelve (12) complete months, starting on the date of entry:

If the date of entry is…	Then the annual period is…
12/13/01	12/13/01 through 12/12/02

Annual Window Period	The twelfth month of the annual period- the month period prior to the end of the annual period:

If the annual period …	Then …
Started 9/16/00 and end 9/15/01	The window period is 8/16/01 through 9/15/01.

Authorization Window Period	The month period prior to the expiration of an authorization:

If the authorization period is…	Then the window period for re-authorization is…
8/2/00 – 11/1/00	10/2/00 – 11/1/00

Transfer Paperwork

Transfer episode defined

When a client transfers from one site to another, a new episode is opened at the new site.

A transfer is considered a transfer under this section if there is a gap of no more than one month between the closing of the first clinics' episode and the opening of the second clinic's episode.

Documents transferred

To facilitate this transfer, the first clinic will send the second clinic copies of the most recent:

- SIMON Registration form
- Outpatient Consent for Treatment
- Diagnosis Sheet
- Clinical Assessment
- Medicare Affirmation and Notice
- CalWORKS check sheet and JESD release (if present)
- Client Plan
- Care Necessity form
- Meds Order sheet
- Client Resource Evaluation
- Discharge Summary

Document distribution

Transfer documents are distributed in the following manner:

- Originals will remain in the first clinic's chart.
- Copies will be a permanent part of the new chart and will be marked as follows: **COPY STAYS IN [name of clinic] EPISODE.**

Second clinic responsibilities

The second clinic does not need to re-do the following forms:

- Clerical (blue) Initial Contact form
- SIMON registrations
- Care Necessity form
- Outpatient Consent for Treatment

But will re-do the following forms:

- Episode Opening form (SIMON)
- Meds Consent for Treatment
- Client Plan (if the current Plan is not used)

The second clinic will add new information, if applicable, to the clinical Assessment (or complete the Clinical Assessment Update).

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Form completion schedule

Forms that are transferred to the new chart by copy will then be on a completion schedule determined by the new date of registration.

Chart closure

When a chart is closed and episoded, the following steps occur:

Step	Who completes	Action
1	First clinic	Sends the chart itself to Medical Records in the BHRC.
2	Medical Records	Sends that episode on to the new clinic as needed.

Concurrent Episodes

The same procedures stated above apply when a client starts services at a new site and the previous clinic continues its services,

Unanticipated services provided at another site

When another site (where the client does not have an open episode) provides an unanticipated service to a client, the clinic with the client's already open episode will provide appropriate paperwork to the second clinic, by fax if necessary.

In the case of an **emergency meds service**, this consists of copies of the:

- Client's meds order sheet
- Last MD ID note

Note: If a service is provided at a site without an open episode, a copy of a chart note for that service will be sent to the client's regular clinic.

Transfers

Policy

When an episode is to be closed and the client transferred to another DBH or contract unit, all providers at the current site are consulted before the decision to close is made.

If…	**Then the…**
There are questions about the appropriateness of transfer, or	Supervisor or Team is consulted.
Providers disagree about closure,	

New Site

The site of new services consulted. Use the **"IF/Then"** table for possible outcomes:

If…	**Then…**
That site does not wish to accept transfer,	The respective Program Managers can be re quested to work out the problem.
Receiving Clinic Supervisor or Team agrees to the transfer,	An appointment may be made for the client at the receiving clinic.

Discharge summary

The following procedure is followed when the discharge has been approved:

Step	**Action**
1	A Discharge Summary is done, if the case has been open at the site for more than 60 days, and
2	The chart episode is closed before transfer, and
3	The episode is closed in SIMON. (This closure need not be coordinated with other sites.)
4	The chart is then sent to Central Medical Records, which will send it on to the receiving clinic.

Dual-Diagnosis Services in DBH Outpatient Clinics

Definition

Dual-diagnosis services may be provided for clients with both mental illness and substance-related problems.

Focus of service

Dual-diagnosis services provided by the mental health clinics of the Department of Behavioral Health ***must focus*** on the mental/behavioral health needs of the client. Dealing with mental/behavioral health concepts and needs is acceptable including how the client:

- Recognizes and attempts to meet needs
- Deals with emotions
- Makes plans
- Carries out responsibilities, etc.

If…	**Then…**
Services provided which ***focus on sobriety or dealing with aspects of the client's substance use or dependence*** (whether to use, how much to use, how to quite, etc)	Services will be subject to ***audit disallowance.***

Diagnosis

Substance-related diagnoses must be secondary diagnoses for these clients.

Dual-Diagnosis groups

Billable groups of dual-diagnosis clients must be either:

- Rehab-ADL groups (MHS-rehab/ADL-group)
- Psychotherapy groups (MHS-group)

Only these services may be provided to clients in these groups. Charting and billing clients in these groups for Collateral or Case Management (instead of for group) is not allowed.

AB3632 Clinical Assessment

Purpose

An adaptation of the Clinical Assessment has been designed to serve for **AB3632** cases as both a Clinical Assessment and an **AB3632** assessment.

Instructions

The same instructions as in the **Clinical Assessment** section apply to filling out the AB3632 Clinical Assessment. Instructions for the specifically **AB3632** section regarding the following topics:

- Reports of records
- Interviews
- Testing
- Eligibility

Can be found in the **AB3632** manual.

Distribution of Assessment

The following steps are followed in distributing of the **AB3632** Clinical Assessment to the school:

Sent to the School	Not Sent to School (Retained at DBH)
• First five pages of the **AB3632** Clinical Assessment as an AB3632 assessment • A copy of the MHS Service Plan	• The Mental Status section of the **AB3632** Clinical Assessment and • Final page of the intake

Clinical Assessment - Adult

Structure

The Adult Clinical Assessment has (2) sections:

- Section A-1 – Initial Assessment
- Section A-2 - Provides additional assessment information about the client for treatment planning.

Each section has certain labeled parts that must be filled out by an LPHA. Each section may be billed separately (or the two may be billed as a unit).

Time Frame

Section A-1 will be done to establish medical necessity. Refer to Instructions specific to complete Section A-1. Section A-2 should be completed before the Client Plan is done and planned services are provided. It is updated at any point if additional significant information becomes available and if the clinical picture changes significantly enough that the first assessment is not consistent with current treatment.

Use of Previous Assessments

If opened episode is . . .	Then . . .
Less than 2 yrs old	Assessment may be updated
More than 2 yrs old	New Assessment must be competed

- The previous assessment is stapled behind a fresh Clinical Assessment form. On this fresh Clinical Assessment form, update various sections as needed, and write, "See previous intake attached" in sections where information is unchanged.
- In all cases, the sections for Presenting Problem and Mental Status must be done completely anew.

Additional Information during an Episode

When additional assessment information becomes known during an episode, it is written on the Assessment Addendum section, which is the final page of the Clinical Assessment, with the writer's signature and date.

When the Form Is Filled Up

If there is not enough room on the form for additional information, insert the needed single blank page of the Assessment into the page sequence, immediately in front of the already full page, write "ADDENDUM" beside the page number at the bottom of the page, and enter any new or changed information, with the date and the writer's initials, and a signature in the

Clinical Assessment - Adult

When the Form Is Filled Up (continued)

Assessment signature block with that date. To add information to the already-printed on-screen version, type or write it on a blank piece of paper, labeled with the client's name, chart number, date of birth, and program name, date and sign it (along with your printed name), and add it to the Clinical Assessment.

Completing the Form

ALL sections and items must be completed for the assessment to be considered adequate. Enter N/A if the item is somehow not applicable, or "N/AV" if the information is not available (e.g., because the client or collateral persons cannot give the information). In general, checking "None" or "No problem" eliminates the need for a written entry for that item, whereas checking that some aspect of the item is present does require a written explanation if space for writing is provided.

The Goal: A Clinical Assessment that describes the client in depth and comprehensively, that illustrates any medical necessity present, and that provides a good symptomatic and historical basis for a DSM-4 diagnosis.

Section A-1 Assessment for Medical Necessity

A. PRESENTING PROBLEMS (Including Mental Status Exam): Include when the presenting problems began and what behaviors or circumstances led to the need for the present assessment. The presenting problems lead into an assessment of dysfunction resultant of the mental disorder.

B. DYSFUNCTION: An assessment of how the symptoms of a mental disorder impair functioning must be documented in the five global areas. As you evaluate each area, be thinking about how you will answer the following questions:

- Does the client have, as a result of a mental disorder, a significant impairment in an important area of life functioning?
- Is there a probability of significant deterioration in an important area of life functioning?
- Is there a probability that the client (for children only) will not progress developmentally as individually appropriate?
- For full scope Medi-cal beneficiaries under the age of 21, is there a condition as a result of a mental disorder that Specialty Mental health services can correct or ameliorate?

Section A-1 Assessment for Medical Necessity (continued)

1) Health/Self-Care: If applicable, how does the mental disorder impair the consumer's ability to care for his or her health? Document how the consumer is unable to manage his/her health and or self care. For example, poor hygiene, medical conditions are left untreated and that are potentially serious in nature. Multiple visits to the Emergency room for pseudo-medical reasons, (i.e. the consumer believes he/she is having a heart attack when in fact; he/she is experiencing a panic attack).

2) Occupation/Academic: If applicable, describe how the mental disorder impairs occupational functioning. For example, the consumer is unable to work, has been fired from jobs, and/or has repeated workplace conflicts or significant work performance problems.

3) Legal/Community Functioning: If applicable, discuss legal difficulties as a result of the mental health symptoms. For example, the consumer has repeated encounters with law enforcement, has had involuntary hospitalizations, and/or is on conservatorship.

4) Financial: If applicable, describe financial difficulties that have a relationship to the mental disorder. For example, a bipolar disordered consumer may result in the client engaging in shopping sprees which results in his or her inability to pay the bills.

5) Interpersonal/Family: If applicable, describe interpersonal relationship difficulties among family members, work associates, and or friends. For example, the consumer may have alienated his/her family, has conflicts with peers, has few or no friends, and/or has been victimized repeatedly.

C. ASSESSMENT OF RISK: In all cases, a risk assessment must be conducted.

1) Examine whether a consumer is a danger to himself. Are there suicidal ideations? Is there a plan? Does he or she have the means to carry out the plan, (i.e. he/she has access to a gun). Sometimes people feel like life isn't worth living or wish he/she were dead. While this is a risk, it is not as high of a risk as someone with suicidal ideations with a plan. Explore the history of previous suicide attempts. If the risk is high, there needs to be consideration for psychiatric hospitalization.

2) A risk assessment for a danger to others must be conducted. Sometimes consumers have paranoid delusions or command hallucinations which may put others at risks. There does not need to be an intended victim for the consumer to be considered high risk. However, if there is an intended victim, then Tarasoff procedures must be followed. Tarasoff procedures are listed in the SPM, policy number CLP820 (05/07) that can be found online on the DBH intranet under "manuals". If the risk is high, there needs to be consideration for psychiatric hospitalization.

Section A-1 Assessment for Medical Necessity (continued)

3) If a client appears gravely disabled as evidenced by the inability to provide food, clothing and shelter as a result of a mental disorder (adult) or unable to accept food, clothing, or shelter as a result of a mental disorder (child) then psychiatric hospitalization should be considered.

4) Suicide HX: Include history or ideations and/or gestures and resultant consequences.

5) Homicide HX: Include history or ideation and/or gestures and resultant consequences.

D. SUBSTANCE ABUSE: Since a "covered diagnosis" per Title IX must be a mental health diagnosis, it is important to rule out substance abuse or dependence as a primary issue. However, it is extremely important to know about co-occurring or co-existing conditions. Consider if there is a history of mental health symptoms prior to, or in absence of, substance abuse. Always document drugs used and date of last use. A consumer with a primary substance abuse disorder must be referred to an alcohol and drug treatment provider. Remember, Mental Health Services delivered to consumers with a primary substance abuse disorder are not billable to Medi-Cal. For Mental Health Services to be eligible for Medi-Cal reimbursement, the client must have a primary mental health diagnosis. Consumers with secondary substance abuse disorders should be referred to an alcohol and drug treatment provider or a co-occurring provider within the clinic if available.

E. MEDICATION: It is useful to know about current and past medication, especially psychotropic medication. A history of psychotropic medications may assist the clinician in determining whether medical necessity is met. Consumers who could have a primary care physician (PCP) prescribe medication (i.e. anti-depressants) should be referred back to their PCP unless the PCP is referring to a DBH psychiatrist because s/he cannot stabilize the clients condition.

F. DIAGNOSIS: Provide the DX based on symptom presentation and clinical determination (even if provisional).

G. DISPOSITION: This is a synthesis of the evaluation which supports why or why not a case will be opened. Needed modalities can also be addressed in this section.

H. CASE STATUS: There are five check boxes that summarize whether a case is being opened or not. If a case is not opened and the consumer has Medi-Cal then a NOA is required. Please see the Standard Practice Manual, policy number QM 06-6007 for further guidance on NOA's. It is also important to document referrals or the rationale that mental health services are not required. Please note the contact information for the referral site you have sent the client to in the Disposition plan. This will be used in follow-up activities with the client if they return to the crisis walk-in clinic.

I. SIGNATURE: The person completing the form will sign at the bottom of the form.

Clinical Assessment - Adult

Use of Database

A. Section A-1 of the Assessment is a complete assessment to establish Medical Necessity. If it is determined that the client's needs may be met without a case opening (through referral, NOA, etc) the Assessment is concluded. If it is determined that the client meets Medical Necessity, and that the case is to be opened, then Section A-2 of the Assessment (additional history and further elaboration of elements identified in the Assessment Section A-1 is to be completed (either at this time, or at another scheduled time).

B. The information gathered in Section A-1 of the Assessment is the information used for data input for the Assessment Tracking Log (PASS) data base, only if the case will not be opened at the Clinic.

Section A-2 Additional Assessment Information

A. HEADING: Complete the Date, billing Time and Location

B. GENDER: Self Explanatory

C. AGE: Self Explanatory

D. MARITAL STATUS (current): Stands for the following:

- S - single
- M - married
- D - divorced
- W - widowed
- Sep - separated

E. LIVES IN/WITH refers to the client's living arrangement.

F. PERSON GIVING TREATMENT CONSENT AND REFERRAL SOURCE: Self explanatory

G. PREVIOUS INPATIENT AND OUTPATIENT TX: Include when, where, duration, why, and provider

H. CURRENT HEALTH CONDITIONS PLACING CLIENT A SPECIAL RISK: Self Explanatory

I. CURRENTLY PREGNANT: Self Explanatory

J. ALLERGIES, SLEEPING/EATING PROBLEMS: Self explanatory

K. OTHER AGENCIES/PROVIDERS CLIENT IS INVOLVED WITH: Self explanatory

L. EDUCATION AND EMPLOYMENT HX, ARRESTS AND LEGAL PROBLEMS: Self explanatory

M. CULTURAL ISSUES: Follow the instructions regarding the screen questions. If a more thorough assessment for cultural or sexual orientation issues is indicated, there are guideline questions available. It is assumed that understanding every client's cultural background and other diversity issues is necessary in order to provide effective care, so cultural/diversity information relevant to treatment should always be entered if known. If a more thorough assessment is done, it is written on pink ID note pages or typed on white paper and inserted after page 2.

Section A-2 Additional Assessment Information (continued)

N. SEXUAL ORIENTATION ISSUES: Self explanatory

O. FAMILY SUPPORT: Determine from the two questions whether the family's support and involvement are important (or necessary) to the client, and whether the client would like to have family involved in some way in his/her treatment.

P. CLIENT STRENGTHS should be personal strengths, abilities, etc., (e.g., highly motivated to improve) rather than circumstantial or environmental advantages (e.g., has SSI, can always turn to mother when in trouble)

Q. MENTAL STATUS:

1) THOUGHT PROCESS means the general quality and adequacy of understanding, reasoning, planning, and other cognitive processes.

2) DELUSIONS. Troublesome thought content, including delusions, is described under Thought Content/Delusions.

3) HALLUCINATIONS. Perceptual problems and hallucinations are described in Perceptual Processes/Hallucinations.

4) MOOD. Mood is usually a longer-lasting emotional state, while affect is the instantaneous emotional "feel" or "coloring" of what is expressed. Be sure to differentiate appropriately between mania and hypomania.

R. DISPOSITION: document any dispositional actions taken (referral to another clinic or to individual or group therapy, day treatment, medication evaluation, ARMC-BH; mandated reports filed; etc.), and any recommendations and other community referrals given to the client or family.

S. SIGNATURES: Each person completing a part of the form will sign at the bottom of the form.

Billing

Both assessment forms stand alone for billing purposes, as long as the top line is completed (date, billing time, location, and service type which is ASSESSMENT). No separate ID note is required; although it is sometimes useful for auditors if a note is entered indicating simply that the Assessment was completed as of the current date. (If a billing time is entered on that ID note, place the time in parentheses, indicating that it is not a separate billing.)

Clinical Assessment – Child/Adolescent

Structure

The Clinical Assessment has two sections. The first two pages are the screening/triage form, and the second part provides additional assessment information about the client. Each section has certain labeled parts that must be filled out by an LPHA. Each section may be billed separately (or the two may be billed as a unit).

Time Frame

All sections of the Clinical Assessment (intake) are completed during the initial intake period, before the Client Plan is done, and they are stapled together and placed under the Assessment tab at the end of the chart. It is updated at any point if additional significant information becomes available and if the clinical picture changes significantly enough that the first assessment is not consistent with current treatment.

Use of Previous Assessments

If an episode is opened, and the previous Clinical Assessment (or similarly complete assessment from another facility) is less than two years old, an update may be done. The previous intake is stapled behind a fresh Clinical Assessment form. On this fresh Clinical Assessment form, update various sections as needed, and write, "see previous intake attached" in sections where information is unchanged. In all cases, the sections for Presenting Problem and Mental Status must be done completely anew. If an episode is opened, and the previous Clinical Assessment is more than two years old, then a new, complete Clinical Assessment is done.

Additional information during an episode

If additional assessment information becomes known during an episode, it is written on the final page of the Clinical Assessment, which is labeled Assessment Update, with the writer's signature and date.

When the form is filled up.

If there is not enough room on the form for additional information, insert the needed single blank page of the Assessment into the page sequence, immediately in front of the already full page, write "ADDENDUM" beside the page number at the bottom of the page, and enter any new or changed information, with the date and the writer's initials, and a signature in the Assessment signature block with that date. (To add information to the already-printed on-screen version, type or write it on a blank piece of paper, labeled with the client's name, chart number, date of birth, and program name, date and sign it (along with your printed name), and add it to the Clinical Assessment.

Continued on next page

Completing the form

ALL sections and items must be completed for the assessment to be considered adequate. Enter N/A if the item is somehow not applicable, or "N/AV" if the information is not available (e.g., because the client or collateral persons cannot give the information). In general, checking "None" or "No problem" eliminates the need for a written entry for that item, whereas checking that some aspect of the item is present does require a written explanation if space for writing is provided. The goal is a Clinical Assessment that describes the client in depth and comprehensively, that illustrates any medical necessity present, and that provides a good symptomatic and historical basis for a DSM-4 diagnosis.

A. MARITAL STATUS: "S M D W Sep" stands for single, married, divorced, widowed, and separated. Note the client's current status.

B. "Lives In/With" refers to the client's living arrangement.

C. PRESENTING PROBLEM: Include when the presenting problems began and what behaviors or circumstances led to the need for the present assessment. Describe problems in daily functioning, such as with responsibilities, social relations, living arrangement, and health.

D. SUBSTANCE USE: Ask initial questions assuming that the client has used substances ("When was the last time...?" rather than "Have you ever...?"), since that is more likely to produce important information. If the client consistently indicates not using a substance, then later questions in the sequence become less relevant for that substance.

E. MOTIVATION AND REASONS FOR TREATMENT: These questions are intended to help the treatment teams assess what the client is adequately motivated to do in treatment.

F. CULTURAL ISSUES: Follow the instructions regarding the screen questions. If a more thorough assessment for cultural or sexual orientation issues is indicated, there are guideline questions available. It is assumed that understanding every client's cultural background and other diversity issues is necessary in order to provide effective care, so cultural/diversity information relevant to treatment should always be entered if known. If a more thorough assessment is done, it is written on pink ID note pages or typed on white paper and inserted after page 2.

G. FAMILY SUPPORT: Determine from the two questions whether the family's support and involvement are important (or necessary) to the client, and whether the client would like to have family involved in some way in his/her treatment.

Continued on next page

Completing the form (continued)

H. MENTAL STATUS:

1. THOUGHT PROCESS means the general quality and adequacy of understanding, reasoning, planning, and other cognitive processes.
2. DELUSIONS. Troublesome thought content, including delusions, is described under Thought Content/Delusions.
3. HALLUCINATIONS. Perceptual problems and hallucinations are described in Perceptual Processes/Hallucinations.
4. MOOD. Mood is usually a longer-lasting emotional state, while affect is the instantaneous emotional "feel" or "coloring" of what is expressed. Be sure to differentiate appropriately between mania and hypomania.

I. "Current Health Conditions Placing Client At Special Risk" are health problems of which all providers should be aware, such as a serious heart condition, diabetes, aneurysm, HIV/AIDS, cancer, etc.

J. "Client Strengths" should be personal strengths, abilities, etc., (e.g., highly motivated to improve) rather than circumstantial or environmental advantages (e.g., has SSI, can always turn to mother when in trouble).

K. DYSFUNCTION: Explain clearly in this section the daily dysfunction that justifies services for the client.

L. "Formulation/Explanation of Problems" is an optional area, which may be used to summarize the assessment data and/or put it in a theoretical context.

M. In "DISPOSITION," document any dispositional actions taken (referral to another clinic or to individual or group therapy, day treatment, medication evaluation, ARMC-BH; mandated reports filed; etc.), and any recommendations and other community referrals given to the client or family.

N. SIGNATURES: Each person completing a part of the form will sign at the bottom of the form.

Billing

Both assessment forms stand alone for billing purposes, as long as the top line is completed (date, billing time, location, and service type which is ASSESSMENT). No separate ID note is required; although it is sometimes useful for auditors if a note is entered indicating simply that the Assessment was completed as of the current date. (If a billing time is entered on that ID note, place the time in parentheses, indicating that it is not a separate billing.)

Psychiatric Evaluation For Children and For Adults

Psychiatric Evaluation form	The appropriate Psychiatric Evaluation form (for children or for adults) will be used for the required psychiatric evaluation for all clients receiving medication services. It will be completed before medications are prescribed (except in some exceptional or emergency situations) and will be filed in the chart in the back section under the Evaluation/Admission tab.
Completing the form	(See Clinical Assessment section for general instructions for all assessments.) Every blank must be completed, if only with N/A or N/Av (not available).
Diagnostic Impression	Note that the official diagnosis for the client is the one written on the blue Diagnosis form. All staff involved in diagnosing a client should meet to resolve differences in diagnostic impression.
Management	Note that recommendations in "Management" must be communicated through appropriate channels to other staff if they are to be involved in the care of the client.
Billing	The form stands alone for billing and does not require an accompanying ID note.

Client Recovery Evaluation

Purpose

The **Client Recovery Evaluation (CRE)** provides for a structured assessment of client community and other functioning and is one method of clearly documenting medical necessity and need for services.

Form used as tool

The **CRE** is **not required** but is a useful tool to:

- Document medical necessity
- Assess a client's needs for service planning

Form completion

In completing the **CRE** describe the:

- Client
- Client's functioning
- Client's situation in such a way that makes clear the need for services
- Client's problems and strengths

Note: Give examples wherever possible.

Substance problems

If substance problems are described, consider whether an additional substance-related diagnosis should be added to the client's diagnosis

Client Functioning and Symptomatology

The focus of the form is largely on functioning, but the section for **"Significant Symptomatology"** should be used to include significant symptoms, such as:

- Mood problems
- Dissociative problems
- Psychotic features

Client progress

In **"Progress with Recovery and Goals",** describe the client's progress over the past year.

Client impairments

In **"Impairment…"** tell why the client needs services and describe the dysfunction that justifies payment for those services

Continued on next page

Signatures

The form may be completed and signed by any clinical staff, including:

- Mental Health Specialists
- Social Worker II's

See **Co-Signatures** section for co-signature instructions.

Client Recovery Plan

Purpose

The **Client Recovery Plan** covers the following areas and is required for all services:

- Specifies the goals for treatment
- Describes services to be provided to the client
- Provides documentation of client participation in treatment planning
- Serves as a vehicle for review of certain services

Exceptions

It is not required to have **Client Recovery Plans** for:

- IMD clients
- State hospital clients
- Non-Medi-Cal CONREP clients

Services included in the plan

The following guidelines apply to services provided to the client under the **Client Recovery Plan**:

- All services (except TBS, which has its own plan) must have plans using the client's **Client Recovery Plan**
- Only services that are provided at a given site will be included on that site's **Client Recovery Plan**
- Separate **Client Recovery Plan** pages may be used for separate services, if desired
- Occasional, unplanned services do not require a Client Recovery Plan, but documentation must support Medical Necessity for their provision
- The following chart applies to clients who transfer to other DBH sites:

If a …	**And…**	**Then…**
Client transfers to another site	There is still authorized time on the **Client Recovery Plan**,	The new site may continue to provide services according to the old **Client Recovery Plan** until its expiration.

Continued on next page

Timelines

The following timelines/requirements apply when completing the **Client Recovery Plan**:

If…	Then…
Services are to continue past the initial two-month intake period,	The **Client Recovery Plan** will be completed within two months of entry.
Example: Entry on May 17 would require a **Client Recovery Plan** no later than July 16. However, the **CRP** should be completed as soon as possible following the completion of the Assessment.	

- Client Plans drive services.
- In exceptional circumstances, if a service (other than Assessment, Crisis Intervention, and/or Plan Development) is provided during the intake period, before completion of the client recovery plan, it must be documented to demonstrate the Medical Necessity for that service. That is: 1) the Diagnosis sheet, must include, a covered diagnosis (even if provisional), and the gathered assessment information, to date, should be sufficient to support that Diagnosis; 2) the impairments must be adequately described (in the progress note), and be significant, to justify the service before intake completion; 3) the planned intervention will address the impairment condition (documented in the progress note); and 4) the client had input into the provision of the intervention and was in agreement with its provision (documented in the progress note).
- ***Best Practice:*** *Good clinical practice includes completion of assessment and client planning as soon as possible, so clinicians and doctors are urged to complete plans as soon as possible.*

The Client Recovery Plan for each service must be re-written every 12 months.

Coordination of services at multiple sites

The process for co-ordination of services at multiple sites is as follows:

Step	Who Completes	Action
1	Clinic staff	Before opening a service episode or adding a service, check SIMON for existing services for that client. (This will prevent duplication of services).
2	Supervisor or Team	• Call ***all*** sites providing services • Discuss the advisability of starting or adding proposed services – This ***must*** be done if other sites are providing **ANY TYPE** of other services). • Staff need not be in agreement about adding the service, but must discuss the matter

3	Supervisor or Team	Chart this coordination effort (including the reason for opening the new service, even if the other sites do not recommend doing that).

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Clients who will receive team oversight

The following criteria applies to those clients who may be considered appropriate for team rather than non-team oversight:

- At any point in the care sequence (but usually during assessment), a client may be identified as a client for whom a team should take responsibility
- Non-team clients will not become the responsibility of a team and will be overseen by clinic supervisory staff, in accordance with written Department criteria for team versus non-team clients

The following chart delineates "Team" from "Non-Team" clients:

Team	Non-Team
Clients who have serious disruption of daily community functioning due to mental disorder.	Cases that are "simpler" and can be appropriately managed by a single provider
Cases of sufficient complexity or severity that the joint care planning of a team or the joint services of various team members is needed if the client is to be properly served.	
Clients receiving DTI or DTR services.	

Billing without authorization

It is the intent of the Department that all care will:

- Have appropriate oversight
- Be carried out with benefit of a **Client Recovery Plan**
  - That there will be no periods of care for which there is no operative **Client Recovery Plan,** with the exception of the intake period if services (e.g.- Assessment, Crisis Intervention, Plan Development) do not go beyond that intake point

The feature of SIMON that will not bill a service unless an authorization is on file in SIMON for that service has been ***turned off.*** This actions was taken because it is believed that:

- Local oversight by supervisors and teams is sufficient to ensure that almost all services are appropriately authorized
- Current blockage of billing due to entry errors - where a service is in fact properly authorized in the chart but not in SIMON - are greater than any recoupment by third-party payors that could occur for services that are billed but turn out not to have been properly authorized

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Who completes the CRP?

The following staff completes the **Client Recovery Plan**:

- Clinic staff or the team will complete the **Client Recovery Plan**
- Staff or the team may subsequently prepare new **Client Recovery Plan Sections** for their services
- Several staff members may enter information on the **Client Recovery Plan**
- Persons signing the **Client Recovery Plan** as '"Provider" must be clinic staff members who are qualified to provide that service, and may include the Service Coordinator Team leader
- An M.D. must sign for MSS services, however:
  - Another staff member may check the box at the top indicating that MSS services are being or will be provided.

Diagnostic Symptoms and related impairments

The following are guidelines for completion of the Diagnostic Symptoms and related impairments section of the **Client Recovery Plan:**

- Diagnostic Symptoms should reflect the predominant symptoms, consistent with the Assessment data, and contributory to the functional impairments for the client
- Functional impairments should be listed and operationally defined. They should be individually based and represent how diagnostic symptoms present themselves in observable/measurable behavioral events or episodes.

Continued on next page

Clients' desired outcomes

The following are guidelines for completion of the Clients' Desired Outcomes section of the Client Recovery Plan:

- Using the client's own words is desirable in this section
- Should be relevant to presenting problem information gathered from Assessment.
- The client's desired outcomes for services should have priority, as long as they:
  - Are related to community functioning
  - Require DBH services for their achievement

Client Driven goals. Behavioral, Measurable, Relevant Objectives, Related to Community functioning

The following criteria apply to charting behavioral, measurable and relevant objectives (negotiated with individual)

Include the elements of a well written and complete behavioral goal.

- Relevant to the client's operationally defined functional impairments
- Measurable by frequency, duration, and/or intensity or some combination thereof.
- Contrast baseline measurement with goal objective.
- Provide a means of measurement

The following chart shows examples of treatment goals and behavioral, measurable and relevant objectives.

Client Desired Outcome	Client Driven Goal
"Control my temper"	• To be achieved by xx/xx/xx. Client will reduce anger outbursts (as described in Dx Symptoms and related impairments section) from 5 times per wk. to a goal of 0 times per wk and sustain for 3 mos. as measured by teacher/parent report.
"To get and maintain a job"	• To be achieved by xx/xx/xx. Client will increase productive job seeking behaviors (describe in Dx Symptoms and related impairments, how the current condition impairs this action, and operationally define "productive job seeking behavior") from 0 times per week to a goal of 4 times per week and sustain for 3 months, as measured by client report.

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Client Desired Outcome	Client Driven Goal
"Get out of the house". "Not be so alone".	• To be achieved by xx/xx/xx. Client will reduce isolative episodes *(as described in Dx Symptoms and related impairments section)* from 7 times per week to a goal of less than 2 times per week and sustain for 3 months as measured by self report and caregiver report.
"Not think about suicide"	• To be achieved by xx/xx/xx. Client will reduce suicidal ideations and gestures *(as described in Dx Symptoms and related impairments section)* from 7 times per week to a goal of 0 times per week and sustain for 6 months as measured by self report and provider observation.

Objective specifics Reviewed

Objectives must:

- Be time-framed in terms of when:
  - They are expected to be accomplished
  - It will be measured as to whether or not they have been accomplished
  - An actual date or dates, must be entered
- Include a method of measurement, which could be stated in any of the following ways:
  - "By client report"
  - "As indicated in the chart"
  - "By parent report
- Operate within the Medi-Cal Rehabilitation Option
  - Requires that objectives be related to the client's community functioning, rather than to changes in symptoms or subjective state
- Be relevant
  - Clearly and reasonably connected to the client's presenting issues, central complaint, or areas of dysfunction
- Be relevant (as defined above) and related to the client's community functioning
- Be measurable
  - The provider's judgment or opinion regarding reaching the treatment goal or readiness to terminate treatment cannot substitute for an observable criterion. Since they are measurable, the objectives could theoretically be assessed by an outside observer based on the objective's language

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Other considerations

Other things to consider when developing an objective are:

- One treatment modality and objective are sufficient for a treatment episode
- One objective may be sufficient:
  - Even if there are multiple goals, depending on the client's readiness to change
  - For several modalities
- Clients should participate in determining the objectives, so that they will know how to take greatest advantage of the services available, and clients will normally be given a copy of their **Client Recovery Plan**
- The amount of services available to any one client will depend on:
  - Client need
  - Resources available at that time, as determined by the Department, the supervisor, or the team
- The following chart applies to when a client reaches their goal or maximum benefit:

If…	**Then…**
Objectives are reached before: • Goal dates, or • End of the authorization period	Treatment will stop at that point unless new objectives are written in the **Client Recovery Plan**
Client has reached maximum benefit from treatment, regardless of whether the end of the authorization period has been reached.	

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Service Coordinator/ Provider Actions

Use the following steps when completing the Service coordinator/Provider Actions section of the **Client Recovery Plan:**

Step	Section	Action
1	Type of Treatment	Enter each type of treatment to be provided in a separate Client **Recovery Plan modality** section. Enter the sub-type as well • MHS – ind. ther. • MHS – group ther. • CM – L&C Use the abbreviations specified in the **General Instructions for All Interdisciplinary Notes** section of this handbook. More than one type of MHS service may be placed in one section of the **Client Recovery Plan**, if they have the same foci of treatment, but the frequencies of each must be specified separately.
2	Enter the frequency of client/provider contact for each proposed modality (once/wk., etc.).	• If more than one service in a modality is planned, clearly list the frequency for each. • For services in which unpredictable variation is expected, enter the expected frequency along with PRN (e.g., “once a month and PRN”. The focus of treatment should relate clearly to accomplishing the treatment goal) • For most cases one, two, or three modalities of treatment will be sufficient
3	Focus/Purpose of treatment	Enter the focus/purpose of the treatment, which is what the provider will focus on or work on in treatment that will help the client to make progress toward the objectives and goals (e.g., “anger management,” or “reduce suicidal ideation and subsequent gestures”)

Continued on next page

Service Coordinator/Provider Actions (continued)

4	Plan start date and end date (duration of treatment) considerations:	• Providers are expected to make services efficient (i.e. to reach client goals as soon as possible) • With some exceptions, treatment of **non-team clients** should be planned from the beginning with an aim toward termination before the end of the first services period. – It is recommended that a termination date be set with these clients, so that both provider and client gauge their work within this time frame. – Clients are informed of this expected termination date and are involved in keeping track of progress and of what remains to be done in the remaining time.
5	Amenability for treatments proposed:	• The client must have the cognitive and emotional abilities to be able to participate actively and benefit from the proposed treatment

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Service Coordinator/Provider Actions (continued)

6	Signatures	The following requirements apply to staff signature on the **Client Recovery Plan**. Every: • Staff member who enters part of the **Client Recovery Plan** will sign the **Client Recovery Plan** • Each time a staff member signs the Plan, he/she affirms that the client participated in developing the Plan • Service Coordinator (Service Coordinator and Provider may be the same) • Supervisor signature required if Service Coordinator is not an LPHA licensed, registered, or waivered Professional.
7	Client/Caregiver Involvement in the Recover Plan	• The client is to be involved in determining the treatment goals and objectives, so that he/she can participate most effectively in the treatment effort • The client's signature will be obtained on every plan, including the initial **Client Recovery Plan** • Clients will normally be given a copy of their **Client Recovery Plan** (with notation of the date it is given). • ***Best Practice:*** It is good clinical practice for parents/guardians of minor clients to be informed about the plan of care and to sign the **Client Recovery Plan**, but if this is not feasible then the signature of the minor child is acceptable

If the client…	**Then…**
Refuses to sign the **Client Recovery Plan**,	As best as possible, ascertain the reason. Renegotiate the goal, if that is the reason.
Agrees with the goal, and the treatment proposed but still refuses to sign the **Client Recovery Plan**,	Note that fact in the signature space, and address the issue in a progress note and obtain the client's signature as soon as it is possible to do so.
Does not agree with the treatment goal or treatment methods,	Consult with he supervisor or team regarding whether treatment should be provided (except for crisis services)

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Service Coordinator/Provider Actions (continued)

8	Effective Period for the **Client Recovery Plan**:	When entering the effective date of the **Client Recovery Plan**, the following rules shall be followed: • The services period for all services may be up to 12 months long • All planned services are authorized for the same time period • The initial date (effective date) of the **Client Recovery Plan** is the: – Plan Start Date, with appropriate signatures. • Date of signature of the **Client Recovery Plan** if completed at any other time. The ending date of a period is entered after "end date" • Each **Client Recovery Plan** will be rewritten on a new form **Note:** Out-of County Medi-Cal cases will follow the authorization periods given by those other counties.

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Changing the Plan

During any services period, providers, supervisors and teams may alter the **Client Recovery Plan**.

- Providers altering a **Client Recovery Plan** need not get approval for the change but must:
  - Document the planned services change in the **Client Recovery Plan**, and
  - Explain the change in an ID note.
- A current **Client Recovery Plan** may be amended to reflect a reduction in the current services period without a re-write of the **Client Recovery Plan**
- Changes are noted on the current **Client Recovery Plan** by:
  - Adding new information and crossing out deleted information, with date and provider initials and signature below
  - Chart note on that same date explaining the change
- A service added during a current authorization period will expire at the end of that authorization period

Location in chart

- All **Client Recovery Plans** will be filed together in the chart at the top of the front left section of the chart, with current services on top, so that providers may check expiration dates easily before each service.
- **Client Recovery Plans** will be filed on top of the Diagnosis sheet, which will be filed on top of the Care Necessity form.
- Providers are urged to review the **Client Recovery Plan** at every client session, for goals and expiration dates.

Termination period

If it is directed that services be terminated, a one-month period will be allowed for appropriate client termination.

Medication Support Services (MSS) Service Plan (Client Plan)

Included documents

The MSS service plan includes the following documents:

- Medication Support Services Plan
- MSS ID notes
- Medication Consent form
- Outpatient Medication Record

Document specifics

Specific information on the service plan documents is included below:

Document Name	Purpose
Medication Support Services Plan	• A plan for all ongoing, planned MSS services must be documented using the Medication Support Services Plan. • The Medication Support Services plan shall be completed by a provider within their scope of practice • All clients, including Meds only (MSS), require the client's signature in addition to the signatory requirements in DBH Information Notice 08-02.
Medication Consent Form	• In the Medications Consent form, documentation of the following information are essential aspects of his/her medications: – Information provided to the client and – The client's indication of participation in the planning for his/her medications • Clients must sign for every change in medication.
Outpatient Medication Record	• The Outpatient Medication Record (or "Meds Order sheet") documents the medications actually provided and the client's ability to participate appropriately in his/her medication planning.
MSS ID Notes	• The MSS ID notes may contain documentation of any of the above plan items and are therefore viewed as part of the MSS plan.

Authorization

It is not currently required that Medication Support Services be authorized

Documentation For MSS Cases

SEE Schedule of Chart Form Due Dates section regarding charting and forms requirements for Medication Cases.

Out-of-County Authorization Form

Overview

The Department's out-of-county authorization form will be used in all charts that are funded by out-of-county Medi-Cal. The following information outlines procedures for initial services and extension of services.

Initial services

New clients with out-of-county Medi-Cal are directed to call their county's access unit for initial approval (usually of a few evaluation visits), or the DBH Access Unit will call the other county. The Access Unit will initiate the out-of-county authorization form (OOCA) and, when the other county's initial authorization is received, the Access Unit will send the OOCA to the clinic as the documentation of the other county's initial authorization. It will be filed in the chart (see filing instructions below).

Extension of services

After the initially authorized evaluation visit or other visits, in order to request further authorization, the provider will complete the initial DBH forms (Clinical Assessment, Client Plan, Care Necessity form, Diagnosis sheet) and send them to the Access Unit along with the OOCA. The Access Unit will forward them to the other county, and when the authorization is returned, the Access Unit will forward that and the updated OOCA to the clinic, which will file it in the chart.

Note: Whenever further out-of-county extensions are needed, the clinic will send to the Access Unit an OOCA along with either the existing Client Plan, Care Necessity form, and Diagnosis sheet, or an updated Client Plan, Care Necessity form, and Diagnosis sheet (see 'the controlling authorization if there are differences' below).

The controlling authorization if there are differences

If the out-of-county authorization and the DBH authorization differ, services will be delivered to the client according to the DBH authorization. The DBH re-authorizations will proceed according to DBH procedures and schedule. Clinics will ensure that out-of-county authorization expirations are monitored separately from DBH authorizations. (A card-file tickler system for all of a clinic's out-of-county clients, that was checked weekly, could be sufficient.) Clinicians will check the out-of-county authorization frequently and will submit re-authorization requests at least three weeks before the out-of-county authorization expires. If the out-of-county authorization expires before the DBH authorization, the existing DBH paperwork (Client Plan, etc.) will be submitted with the OOCA at that time, rather than preparing new DBH paperwork early.

Filing

The OOCA will be filed in the chart in the front left section, on top of the "blues."

Services Team Actions Form

Completion of form

All services team actions regarding the client's care will be documented using this form, including:

- Assignment of providers
- Authorization of services (if required)
- Non-authorization of services
- Team-directed changes in the services provided or the approach used in providing those services
  - Team discussions regarding a client's care that do not result in a team action may be documented either on this form or in an interdisciplinary note.
- It is intended that this form will assist teams in considering whether services are necessary and will help them to document justifications for granting or for not granting authorizations
  - Teams may make decisions about a case that alter the nature of services but which have nothing to do with "authorization,"

If...	Then...
There is no required authorization program that applies to those services	Do not check boxes that refer to "authorization".

Placement

The form is placed in chronological sequence among the other ID notes in the chart.

Billing

Billing information is entered at the top of the form. No additional ID note is required for billing. (See Billing section for procedures for billing by each team member participating of by one team member for all who participate)

Staff and other present

Complete the "Staff and Others Present" section as follows:

Step	Action
1	Check whether the client is present, and enter the names of collateral persons present (family, etc.) and of team members present.
2	Circle the names of those staff members who contributed to the discussion for that client and whose time is therefore being billed. • Names of team members may be pre-entered on the form.
3	If Step 2 is done: • Cross out the names of any not present, and • Circle the names of those for whom billing is being done for that particular client.

Continued on next page

Services Team Actions Form, Continued

Team deliberations and actions	Describe in this section any: • Actions taken • Conceptualizations developed • Changes in providers, frequency, etc. of services
Authorization granted or not granted (if applicable)	The reasons that an authorization is granted or not granted will be explained by checking the appropriate boxes or writing in information. Checking any one box in the section for "...NOT GRANTED..." may be sufficient grounds for not authorizing services.
Team – directed changes in client care	The team may direct a change in the type of services provided, and this may be documented by checking boxes and filling in blanks appropriately.
Signature	Any team member may complete and sign the form. (If a multiple billing is done, the team member doing that billing should sign the form.)

Day Treatment Intensive ID Notes

General instructions

See “General Instructions for All Interdisciplinary Notes” section for general instructions applying to all ID notes.

Requirement

The following notes are required:

- Brief daily ID notes
- Weekly summary of treatment

Other treatment notes may be entered as desired.

Form completion procedure

The following table instructs the user in completion of the Day Treatment Intensive ID notes form.

Step	Section	Action
1	General	The daily notes will be entered on the pink ID note form specifically designed for intensive day treatment only
2	Day Treatment Intensive-Daily/Weekly ID Notes	At the top of the form, enter the week and locations.
3	Status Matrix	• Enter for each day the client’s condition or status as observed. • This should provide justification for further treatment, if further treatment is needed. • Additional symptoms/problems may be added in the blank lines.

Continued on next page

Form completion procedure (continued)

Step	Section	Action
4	Program Matrix	• Enter all planned and available therapeutic activities for the week. • Write in after the headings provided any further specification of the type of group or treatment (such as “AMAC group”). • Add other groups and activities in the blank lines at the bottom. • After this section is filled in, the form may be copied for staff use for that week. • After each activity, write the expected or typical length of the activity (1 hr., 1.5 hrs., etc. • Under each day of the week, place a check mark in the box of each activity in which the client participated. • The location of the service may be noted in the box for each service performed outside the clinic. • Significant absences or partial participation should be explained in the ID notes.
5	Daily Interdisciplinary Notes	• In the “Daily Interdisciplinary Notes” portion of the form, write a brief, one to three sentence note for each day the client attended that week, commenting on the client’s condition and the client’s participation. • Date each note in the left column. • No heading is needed on the daily notes. • An example might be: – “1/12/06 John was distracted by voices telling him to harm self today but responded well to work on this in therapy group. Participated well in recreation group aimed at decreasing his severe depression.” • If more space is needed for one week of daily notes than is available on one page, continue on the second page of the structured form.

Continued on next page

Form completion procedure (continued)

Step	Section	Action
6	Weekly Summary Notes	• In the portion of the structured DTI ID note headed “Weekly Summary,” write the weekly summary note. • ID note content is basically the same as for MHS ID notes, but the note must be more extensive and specific enough to justify the intensive service. • Every note should contain: – A description of the clients current condition and problem being addressed, – The staff’s various interventions throughout the week, – The client’s responses to the interventions, – The client’s treatment–related efforts between sessions if, applicable, – The connection between the treatment provided and the measurable objectives of the client, – Enough indication of medical necessity to justify further treatment, if that is indicated. • Notes need not describe every intervention or meaningful therapeutic interaction for the week, but auditors will expect more than just one, and they will expect specifics rather than generalities. – The description of several interventions and client responses in different activities will probably be sufficient. • Day treatment staff who have treated a given client should share their information with the person writing the weekly summary note before the note is written each week.

Continued on next page

Form completion procedure (continued)

Step	Section	Action
6 con't	Weekly Summary Note (continued)	• The weekly summary note must be written by (or reviewed and co-signed by) an LPHA who is providing DTI services or directing the program. (Depending on the writer, daily notes may need co-signature.) • It is advisable occasionally to give an update as to where the client stands in the overall course of treatment, and to describe the client's reported medication reactions. (If a client is receiving meds from a physician outside the Department, make note of this and of the medicines received.) • Changes in Service Plan or Diagnosis: – If changes are made in the Client Recovery Plan or diagnosis, the reasons for these changes should be clear or should be explained in an ID note dated on or about the same date as the change in the plan or diagnosis

Billing

For instructions on billing unique to day treatment can be found in the "Billing" section of this manual.

Documentation in the Chart of Client Complaints

Reporting options

The following are options for reporting client complaints and incidents;

- Client complaints, including complaints about staff misconduct may be documented in the client's chart, to the extent that such documentation is necessary for follow-up client care
- The client may make his/her own report of the incident to the Quality Assurance system via the grievance forms available in the lobby of each clinic
- Information regarding an alleged incident that is necessary for Departmental investigation and follow-up will be included in a DBH incident report

Charting

Charting related to alleged incidents of staff misconduct will be handled as follows:

- When the complaint is about staff misconduct, it is recommended that initials (and not Names) be used in the chart if it is necessary to identify the staff person at all
- The exact source of information should be identified if information regarding an alleged incident is reported in the chart in the following manner:
  - "The client reported that...", the clinic supervisor, John Doe, reported that...,"etc.
- It is charted in this way because if the provider did not observe the alleged incident, the provider does not know what actually happened

Should information be included?

If it is uncertain about whether or not to include certain information about an alleged incident in the chart, a provider may consult his/her clinic supervisor.

Clinic Supervisor action

The Clinic Supervisor will notify the staff person about whom the complaint is made regarding what information was entered in the client's chart.

Staff action

The staff person may request that this chart be treated as a chart containing "sensitive information" as defined for medical records in SPM 14 – 1.32.

General Instructions for All Interdisciplinary Notes

Names

DBH chart notes are referred to in the following ways:

- Progress note
- Chart note
- Interdisciplinary note
- ID note
- “Pink note”

It is a chronological record of the course of the client’s care in the Department and should contain entries whenever the client does not keep or reschedule an appointment as well as notations of provider attempts to contact the client.

Definition

These notes are the narrative record in the chart of each client. An ID note is written for each of the following events in the course of treatment needing to be recorded for clinical or for legal purposes:

- Face-to-face contact
- Phone calls
- Collateral contacts
- Other events relevant to treatment

Time deadline

The following guidelines apply to the writing of case ID notes:

- Every ID note must be written not later than the day after the service occurs
  - Ideally each ID note would be written the day the services was delivered.
- Every ID note must be filed in the client’s chart no later than 72 hours after the service occurs

Continued on next page

Purpose

ID notes must both:

- Communicate with others who may need to take care of the client
- Document what every provider has done so that those paying for the services will be convinced that appropriate and needed services were delivered

Placement in Chart

The following policies apply to ID notes:

- ID notes are placed in the ID notes section of the chart
- ID notes for various services in the same clinic location will be entered chronologically without being separated by service mode. These services include:
  - Mental Health Services
  - Day Rehabilitation
  - Case Management, etc.
- When an MSS note page is placed on top of a partially filled MHS note page, MHS and other services dated after the date of the meds visit must be written on a new MHS ID page and not on the previous page
- All unused lines on the general ID note page are then diagonally lined out

General instructions and billing

The following are required headings for all notes:

- DATE
- SERVICE DELIVERY TIME
  - Together with charting time and any associated plan development time
- LOCATION
  - See codes at top of the ID note page, and also V-B
- SERVICE MODE AND TYPE
- EXAMPLES would be MHS – IND., DTR-Group, CM-Place., etc.
  - See list of service headings and abbreviations below and on the CDI
  - Example—4-31-95 1:05 1 MHS-IND.
  - See Billing Section for specific group billing instructions

Continued on next page

Location

- The first number of the location code indicates the location of the provider of the service when the service was provided
- These codes are printed at the top of the ID note page and on the CDI.

  "-3" is added if the service was not provided to a client face-to-face
  - For example, individual therapy in the provider's office with the client would have a location code of "1".
  - Individual therapy provided over the phone to a client when the provider is located in a phone booth in the community would have a location code "2-3".
  - Plan Development done in the office by the provider alone would be "1-3".

Time entry

Enter service time (plus charting and associated Plan Development time) in hours and minutes (one hour and 15 minutes is 1:15).

Specific situations

The following chart applies to specific situations in writing ID notes:

If there are...	Then...
Multiple services where significant amounts of more than one service are provided in one session e.g. individual therapy and collateral:	• Write separate notes, and • Bill separately.
Multiple staff where more than one staff member is involved in providing a service	• The initials and billing time of each staff member are listed in the "hrs.-min." column of the ID page • Each staff member is identified by name and discipline in the ID note • A sentence is included in the note telling why more than one provider was needed (except for services team meetings • See Billing section for a group example
Service(s) provided by phone	• Head that note with the activity done followed by "phone" • Individual therapy done in the office over the phone would be headed "MHS-Ind.-phone", with a location code of "1-3"

Continued on next page

Content

ID note contents should be as follows:

Every Note	On occasion	As needed
• A description of the client's current condition • The problem or dysfunction being addressed in the session • Provider interventions, and • The client's response to the interventions	A description of where the client stands in the overall course of treatment	Medication effects

Change in plan or diagnosis

When changes are made to the Client Recovery Plan or the client's diagnosis, an ID note dated on or near the date of the form change should be written to explain the reasons for the change

Intensive outpatient

ID notes for "intensive outpatient" services must describe several interventions and client responses, to justify the greater length of services.

Dual-diagnosis services

See "Dual-Diagnosis Services in DBH Outpatient Clinics" regarding documentation of dual-diagnosis services.

Crisis intervention

In addition to the "Content" section above, Crisis Intervention ID notes must contain a:

- Description of the acute crisis or dysfunction that jeopardized the client's ability to maintain usual community functioning
- Plan for subsequent service, if applicable

Sign each note

Sign each entry made. (See "Signatures" section for signature formats.)

Unused lines

Draw a vertical or diagonal line through every blank line left after an ID page is finished.

Continuing a note

If a note is continued from one page to the next write:

- "Continued" at the bottom of the first page and sign it
- The date and "continued' at the top of the new page

Continued on next page

Client/Clinic information

Each ID note page must include the following:

- Client's name
- Client's chart number
- Client's date of birth
- Name of clinic where the service was provided

Service heading abbreviations

The following are abbreviations used in the Service Heading:

Abbreviation	Description
MHS	Mental Health Services
CM	Case Management
MSS	Medication Support Services
DTI	Day Treatment Intensive
DTR	Day Rehabilitation (If written on the MHS ID note form
CS	Crisis Stabilization
Pl. Dev.	Plan Development Note: Pl. Dev. For MHS is headed "MHS – PL. Dev.", but Pl. Dev. for CM is headed "CM – L&C—Pl. Dev."
Ind.	Individual
Group	Psychotherapy group only
Coll.	Collateral
Assess.	Assessment
Psych. Test.	Psychological Testing
Cr. Int.	Crisis Intervention
Fam. Ther.—Ind.	Family Therapy if only one open chart
Fam. Ther.—Grp.	Family Therapy if two or more open charts
Meds. Visit	If not using MSS structured note
Meds. Support	If not using MSS structured note
CM – L&C	Case Management—Linkage and Consultation
CM—Place.	Case Management—Placement
Rehab/ADL – Ind. – Group – Meds. Ed. Group – Voc.	Rehabilitation/ADL
Voc.	Vocational
Drug S.	Drug Screen
Social.	Socialization
Eval. Or Evaluation	Would be appropriate heading for the Community Functioning Evaluation, which is no longer used.

Continued on next page

Additional information	Also see the CDI for exact abbreviations to use in ID note headings.

Medicare Charting and ID Notes

Policy

All charting for Medicare-billable services will be done according to the instructions in the ”Medicare Charting and ID Notes” section of this manual.

Current billable services

The Medicare-billable services are currently:

- Crisis intervention
- Assessment
- Individual therapy
- Group therapy
- Psychological testing
- Family therapy
- Collateral as it pertains to the above services
- Medications

Reports

The MHS560 and MHS 100 reports identify clients with Medicare.

Reference

See “General Instructions for All Interdisciplinary Notes” for general instructions for all ID notes.

Documents

There are no required Medicare differences in the use of the:

- Clinical Assessment
- Diagnosis page
- Care Necessity form
- Client Recovery Plan
- Consent for Treatment

Advance Beneficiary Notice

The Medicare Advance Beneficiary Notice must be given to Medicare beneficiaries before any service that is not expected to be reimbursed by Medicare.

SIMON

SIMON translates the following from those described elsewhere in this chart manual to the formats required for Medicate billing:

- Diagnosis
- Billing time
- Service type
- Location

Continued on next page

Acceptable services

Medicare pays only for services that are "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member."

Goal of psychotherapy

The Medicare goal of psychotherapy is to:

- Reduce or eliminate symptoms, complaints or impairments that interfere with normal functioning
- Stabilize (or improve) "at-risk" patients with chronic mental illness
  - Maintenance is acceptable as an ongoing goal if justified in relation to what would happen or has happened to the patient when treatment is discontinued

Not billable to Medicare

The following services are not billable to Medicare:

- Psychotherapy for persons who do not have the cognitive capacity to participate in the treatment
  - **Note:** A psychotherapy session cannot last longer than a patient's attention span
- MAA activities are never Medicare billable

Not medically necessary or reasonable

Psychotherapy is not medically necessary or reasonable when:

- There is lack of progress toward improved functioning
- There is deterioration by an SPMI patient being treated
- The therapeutic goal is achieved
- Cognitive or other organic problems, including dementia, preclude participation and benefit
- The patient is delirious
- Substance use interferes with ability to benefit
- The patient refuses to participate
- The patient only needs social, recreational or custodial services

Dementia

Psychotherapy for dementia alone is not appropriate, where as psychotherapy for dementia with depression may be.

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Medicare payment

Services for diagnoses not on the Medicare diagnosis list will not be paid.

The following services are not separately billable to Medicare:

- Collateral
- Plan Development
- Case Management

Rehab/ADL is currently not being billed to Medicare

Patient education

Patient education about the illness and telephone calls are included in service billings and are not billed separately.

Consultation with Primary Care Physician

It is required that at the beginning of care, non-M.D. providers:

- Inform the patient of the desirability of the therapist conferring with the patients PCP, and unless the patient declines
  - Document in chart if the patient declines this contact.
- Provide written notification to the PCP that services are being provided to the patient
- Consult with the PCP in case medical conditions are contributing to the psychological conditions

ID Notes: Stand- Alone concept

Medicare notes should give a reviewer enough information that they would not necessarily need to look at the Client Recovery Plan or Clinical Assessment. Medicare notes are more like traditional physician notes and must have more context and content than Medi-Cal notes.

Medicare note specifics

Use the following chart to determine what to include in the Medicare ID Notes.

Placement	What to Include
In first note or two	Permission to treat: that the client signed the Consent to Treatment form
“	Relevant history of condition requiring treatment include in ID note even though it is in Clinical Assessment

Continued on next page

Medicare note specifics, Continued

Placement	What to Include
In first note or two	Patient's ability and willingness to resolve the mental problems present: • Does the patient have both the ability to take advantage of the treatment and the motivation to do so in a manner that will make the treatment successful? – "Client is of average intelligence and able to participate in psychotherapy. Client is fearful of failure but expresses almost desperate desire to improve depression and return to work."
"	Primary care physicians contact or status (include date of patient's most recent contact with PCP) • I sent notice of proposed services here to Dr. Tolbert Gayton in Rialto, or • "Client requested that we not contact his PCP Dr. Tolbert Gayton in Rialto" whom he most recently visited 1/30/06."
"	Treatment plan including: • Therapeutic interventions • Planned and duration estimate – "Patient agrees to our recommendation of group psychotherapy lasting 16 weeks."
"	If not on meds, document reasons to refer or not to refer for meds.
"	If "interactive psychotherapy" is required, document why.

Continued on next page

Medicare note specifics, Continued

Placement	What to Include
Include in every ID note	• Patient name (at bottom of ID note page is OK • Date of service • Billing time • Patient's conditions, which should indicate continued need for treatment – "For every service billed, providers must indicate the specific sign, symptom, or patient complaint necessitating the service" • What happened during the session in relating to the problem being treated • Intervention used in that session • Active participation by patient (more than just client response • Progress made toward treatment goal • Obstacles to treatment discovered (if any) • Reason for lack of improvement (if none) • Test and exam results (if any) • Consultations and referrals (if any) • Revisions to the diagnosis, goals, or treatment plan (if any) – "See updated Client Recovery Plan as of this date." • Immediate plan for care – "RTC for next ind. ther. 2/27/06" • Signature, legible name and degree of practitioner
Unusual Circumstances	• Long-term psychotherapy requires submitting an updated treatment summary and treatment plan when requested, with prediction of number of visits needed until end of calendar year. • Visits longer than 90 minutes require a written report submitted with the claim • Only exceptional circumstances warrant a 75-80 minute billing

Medicare payment prompts

An ID note page with Medicare content prompts is available

Medication Support Services ID Notes

General

See “General Instructions for All Interdisciplinary Notes” section for general instructions applying to all ID notes.

Structured note form

The following instructions apply to MSS ID notes:

- MSS ID notes will normally be written using the structured, Departmental pink form reserved for these notes only
- Any MSS notes written on the regular MHS ID note form will include the same content as required in the MS ID note form
- The MSS ID note content is considered to be part of the MSS plan of services

Who can use the form

The following instructions apply to those who are authorized to use the MSS ID notes:

- Parts A and B may be used by both physicians and R.N.’s
  - R.N.’s using Part A must include all required content for Part A
- Part B may also be used by psych techs administering medications
- Co-signature is not required for nurses and psych techs using the form to document services they provide that fall within their DBH-authorized scope of practice

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Completing the form

The following sections of the MSS ID notes must be completed as stated below:

Section	Information to be Completed
Note Content	• All sections of Part A must be filled out for visits in which meds are prescribed • All notes (Part A and Part B) must describe staff actions (prescribing meds., etc.) • Fill in the date, billing time and service location
	All meds visit notes must include notations regarding: • Target symptoms: the problem being treated • The client's response to medications • Side effects noted and actions taken in response • Presence/absence of tardive dyskinesia • Client compliance with the medication plan • Medication interventions
	• If any part of the form is not applicable for a given visit, enter N/A • Enter other information if relevant: – Labs – Recovery update, etc.
MSS Groups	• In order for MSS—Group to be charted and billed, the note must contain description of some group process—at a minimum, a group discussion of compliance and/or side effect issues – "Groups" that involve only separate, individual services (and no group interactions) for individuals who happen to be in the same room at the same time should not be charted or billed as group

Termination

If it is planned to terminate medication services at a site, the provider planning the termination should notify all other providers of services to the individual at that site.

(See Client Recovery Plan Section for Medical Service Plan elements)

Abnormal Involuntary Movement Scale (AIMS)

Purpose

This form helps the physician to stay alert regarding involuntary movement effects of medications.

- The form will be completed on all clients being prescribed medications, to establish a baseline
- It will then be repeated annually for those clients receiving neuroleptics

Clozapine Side Effect Checklist

Description

The Clozapine Side Effect Checklist is used to keep a running record of side effects by the week.

Completing the form

The following steps detail completion of this form:

Step	Action
1	• Each column represents a week • Identify the date above and fill in the boxes for each week as indicated, by a check mark or with data regarding that item
2	Physician initials must be entered at the bottom of each column
3	Additional explanation of items may be written at the bottom, and any side effects should also be noted in the MSS ID note for that visit

Medical Codes

Codes

The following is an ICD – 9- CM Codes that Support Medical Necessity (from NHIC materials). Services for other diagnoses will not be paid.

Acceptable ICD-9-CM Codes	Associated Diagnosis Description
290.12	Presenile dementia with delusional features
290.13	Presenile dementia with depressive features
290.20	Senile dementia with delusional features
290.21	Senile dementia with depressive features
290.42	Arteriosclerotic dementia with delusional features
290.43	Arteriosclerotic dementia with depressive features
291.5	Alcohol Jealousy
291.81	Alcohol Withdrawal
291.89	Other specified alcohol psychosis
291.9	Unspecified alcohol psychosis
292.0	Drug withdrawal syndrome
292.8	Drug-induced organic affective syndrome
292.89	Other drug-induced organic personality syndrome
292.9	Unspecified drug-induced mental disorder
293.81	Organic delusional syndrome
293.82	Organic hallucinosis syndrome
293.83	Organic affective syndrome
293.84	Organic anxiety syndrome
293.9	Unspecified transient organic mental disorder
	Other specified organic brain syndromes (chronic) • Epileptic psychosis NOS • Mixed paranoid and affective organic psychotic states
295.00 – 295.95	Schizophrenic Disorders
296.00 – 296.99	Affective psychoses
297.1	Paranoia
297.3	Shared paranoid disorder
298.8	Other and unspecified reactive psychosis
298.9	Unspecified psychosis
299.00	Infantile autism, current or active state
299.10	Disintegrative psychosis, current or active state
299.80	Other specified early childhood psychoses, current or active state
300.00 – 300.9	Neurotic Disorders
301.1 – 301.9	Personality Disorders

Continued on next page

Codes, continued

Acceptable ICD-9-CM Codes	Associated Diagnosis Description
303.90 – 303.92	Other and unspecified alcohol dependence
304.00 – 304.92 (excludes -.03)	Drug dependence, excludes remission subtype **use only the fully detailed codes*
305.00 – 305.92 (excludes - .03	Nondependent abuse of drugs, excludes remission subtype **use only the fully detailed codes*
306.0 – 306.9	Physiological malfunction arising from mental factors
307.0 – 307.9	Special symptoms or syndromes, not elsewhere classified
308.0 – 308.9	Acute reaction to stress
309.00 – 309.9	Adjustment reaction
311	Depressive disorder, not elsewhere classified
312.30	Disorders of impulse control, not elsewhere classified
312.33	Pyromania
312.34	Intermittent explosive disorder
312.81 – 312.89	Other specified disturbance of conduct, not elsewhere classified
312.9	Unspecified disturbance of conduct *(delinquency, juvenile)*
313.0 – 313.9	Disturbance of emotions specific to childhood and adolescence
314.0 – 314.9	Hyperkinetic syndrome of childhood
315.5	Mixed development disorder
315.8	Other specified delays in development
315.9	Unspecified delay in development
316	Psychic factors associated with diseases classified elsewhere
780.52	Other insomnia
995.50 – 995.59	Child maltreatment syndrome
995.80	Adult maltreatment, unspecified
995.81	Adult physical abuse
995.82	Adult emotional abuse
995.83	Adult sexual abuse
995.84	Adult neglect (nutritional)
995.85	Other adult abuse and neglect
V11.0 – V11.9	Personal history of mental disorder

Medications Order Sheet

Directions

Complete all columns (except problem number):

- Date/time
- Medicine
- Dosage
- Frequency
- Route/site of entry
- Number of tablets on hand
- New amount prescribed
- Refills
- Signature

Note: For intramuscular administrations, it is critical to include the time and site of the injection.

Ability to manage meds

A notation regarding the client's ability to manage his/her own medications must be made at the bottom of each Medications Order Sheet.

Clinical Laboratory

Policy and procedure

There should be a baseline laboratory study appropriate to the medication prescribed and annual laboratory studies thereafter. Laboratory reports from an outside clinic or agency within the past year are acceptable.

Specific meds

Appropriately-timed blood level findings should be obtained and on file for clients taking the following medications

- Lithium
- Tegretol
- Dilantin
- Phenobarbital
- Others requiring frequent monitoring

HIV and Aids Charting

Introduction

See the following statement from the Department's Standard Practice Manual.

Policy

Since HIV testing is to remain as confidential as possible in order to encourage more people to consent to be tested, HIV/AIDS status which has been determined by testing in the OADP HIV/AIDS testing and counseling program is to be treated as confidential.

Disclosure of information

Testing program staff will not disclose or release this test status information to anyone without the individual's written permission on the release of information form or as otherwise permitted by law, for example to:

- Employees in DMH or OADP whose work involves contact with bodily fluids of clients.

Notation of information

The law permits notation by HIV/AIDS testing and counseling program staff of HIV results in OADP and DMH client charts, but in order to promote early detection, DMH policy allows OADP HIV/AIDS testing and counseling program staff not to place this HIV/AIDS information in OADP or DMH charts

Reference: Health and Safety Code 199.20 et seq; 42 C.F.R., Para. 2

DMH medical records

Charting by DMH or OADP clinicians or physicians of a client's HIV test results or AIDS diagnosis does not require client authorization if obtained appropriately from:

- Other medical records
- Collateral persons
- Client's disclosure

Reference: California Hospital Assoc., Consent Manual 1995 Edition, Chapter 20.

Continued on next page

Clinician/ Physician decision

Clinicians and physicians may decide whether to chart known HIV/AIDS information regarding a client, but if such information is not charted, the risks of not charting this information to the following persons should be carefully considered:

- Client
- Clinician
- Other health care workers

Where diagnosis is reported

When a client's HIV positive status or AIDS status is charted, the HIV – positive status or AIDS diagnosis can also be recorded on Axis III of the DSM-4 diagnosis if it is relevant to the appropriate management of the case.

Disclosure by staff

Disclosure of a client's HIV/AIDS status through:

- Oral communications
- Written communications
- Disclosure of the medical recorded

Requires that the client specifically authorize the HIV/AIDS disclosure in writing, using the release of information form, except in the following circumstances:

- To another health care practitioner or an agent or employee thereof who provides the client's direct care and treatment. Authorized disclosure under this section does not include:
  - Certain health care services plans. Disclosures to insurance companies are governed by Insurance Code 799 et. seq.
  - Non-treatment personnel of any kind (clerks, janitors, etc.)
- To the clients legal representative, conservator, or the person who gave consent to the client's HIV test;
- To a provider of health care who procures, processes, distributes, or uses a human body part donated pursuant to the Uniform Anatomical Gift Act

Reference: California Hospital Association, Consent Manual, 1995 Edition, Chapter 20:

Continued on next page

Procedure for release of information

The following procedure is used when releasing information regarding the client's HIV/AIDS status.

Step	Action
1	Any DMH employee involved in obtaining client consent to the release of DMH confidential information will ask the client: • "Is there any reason to think that HIV or AIDS information about you might be included in your medical record?" – The client may indicate at that point, without answering the question, that he/she wishes to competed the release process with a specific other person, such as his/her clinician or physician.
2	**If the client answers...** / **Then...** "No" and the staff person involved knows of no HIV/AIDS information in the record, — The release process will proceed as usual "Yes" (or if the client answers "No" but the DMH staff persons involved know that such information is included in the record), — The client will be asked if he/she wishes to consent to release of both psychiatric and HIV/AIDS information in the record.
3	**If...** / **Then...** The client Consents to the release of both psychiatric and HIV/AIDS information, — That fact will be noted non the release form (by writing in the "SPECIFIC TYPES OF INFORMATION" blank "Client consents to the release for any HIV/AIDS information in the recorded at this time"). The client does not consent to the release of HIV/AIDS information, — That fact will not be noted on the release form. The client consents to disclosure of psychiatric information but not HIV/AIDS information, — Disclosures must be so edited and HIV/AIDS information removed from the disclosure, unless otherwise permitted or required by law Editing of HIV/AIDS information is needed prior to a disclosure of client information — A clinician or physician will do this editing, using the directions of Medical Records regarding how to carry out the editing.

Continued on next page

Disclosures to persons in danger of harm

The physician who ordered the antibody test may disclose confirmed positive test results of his or her patient to:

- A person reasonably believed to be the spouse of the patient
- A person reasonably believed to be a sexual partner
- A person with whom the patient has shared the use of hypodermic needles
- The County Health officer

A physician shall not be held civilly or criminally liable for doing so. Prior to disclosing the test result to a third party, a physician must first:

- Discuss the results with the patient
- Counsel the patient
- Attempt to obtain the patients' voluntary consent to notify the patient's contacts

Also, when the physician discloses the information to a contact, the physician must refer that person for appropriate care.

Reference: Health and Safety Code 199.25

Court case

A recent California Court of Appeals decision (Reisner v. Regents of University of California [1995] 31 Cal App. 4th 11-95) indicates that in certain situations physicians may have a duty to warn those who could be harmed by a client's HIV infection. If medical staff are unsure how to proceed in these circumstances, even after carrying out the permissive disclosure in the immediately preceding instructions, see CONSULTATION SECTION below.

Permissive or discretionary disclosure

To date, there is not statutory authorization for permissive or discretionary disclosure of a client's AIDS/HIV status to those described in the immediately preceding instructions by a treating non-physician without a release of information by the client. (See CONSULTATION SECTION below.)

Mandated reporting - general

The law imposes a duty on medical or other personnel providing services in adult correctional or juvenile detention facilities to communicate to the officer in charge information that indicates that an inmate or minor at the facility has been exposed to or infected by the HIV virus.

Continued on next page

Specific requirements

There are currently no mandatory reporting requirements regarding HIV test results or HIV status, but there are reporting requirements regarding a diagnosis of actual AIDS. The following criteria shall be followed:

Reference: California Hospital Association, Consent Manual, 1995 Edition, Chapter 20.

Who Reports	Required Reporting
DMH physicians who makes a diagnosis of AIDS	Should report it immediately to the County Public Health Officer (909) 383-3060
Physicians and hospitals	Must immediately report all transfusion-associated AIDS cases confirmed by the person's physician to the County Health Officer for investigation.
Hospitals	Must report to the State Department of Health Services and the County Health Officer whenever a person is hospitalized whose physician confirms that the person has a diagnosis of AIDS

When report are made

Reports must be made as soon as practicable after hospitalization. These reports must include:

- The person's name
- The person's date of birth
- The person's address
- The person's social security number
- Hospital name
- Date of the person's hospitalization

Liability

There is no liability for hospitals and physicians making these required reports.

Legal requirement

There is no legal requirement that the client be notified regarding these reports.

Consultation

Disclosures of information regarding a person's HIV and/or AIDS status may present legal issues, including occasionally the issue of possible Tarasoff warnings. In the event that a question regarding disclosure is not covered in the material set forth hereinabove, follow the steps below:

Step	Action
1	The clinician's supervisor should be consulted concerning the propriety of releasing confidential information in that given situation.
2	County Counsel can only be contacted via Department administration, by first contacting one's Program Manager II.

Physical Assessment

Description

Form 18x (yellow):

- Verifies that the physician has discussed with the client the need for the client to have a complete physical examination
- Allows client and physician to be fully aware of the client's physical condition and of any contraindications to the use of psychotropic medications

Completing the form

Form 18x is completed as follows:

- The client should be reminded of this annually and the form filled out and signed by the client every year
- The form should be filled under the "Physical" tab in the back of the chart
- A copy of a physical examination from another facility, such as County Medical Center, can be filled in the chart in lieu of Form 18x

(See "Forms in Other Languages" for use of a physical assessment form issued by Quality Management in a language other than English.)

AB2726 Financial Liability for Parents

Description

Parents of children being evaluated for or receiving AB2726 services must be informed of certain financial information regarding payment for the child's services. The form headed "AB2726 Financial Liability" is the record of this process.

This form also details what parents should expect from DMH in the course of evaluation and services

Procedure

The following procedure applies to completion of the form:

Step	Action
1	Parent signs form indicating that they have been informed of these matters.
2	A DMH witness should also sign the form
3	After signatures are obtained, parents shall be given a copy of the form.
4	File the from under the "Identification" tab in the back of the chart.

Charting Interpretation and Service in Non-English Language

Entry detail for interpretation of a service	The person writing the chart note will enter, immediately following the service name (MHS-Ind. Ther.", etc.), "(Interpretation provided in [Specify language] by [name of provider]".
Example	MHS-Ind. Ther. (Interpretation provided in Spanish by Adam Articulate)...
Entry detail for provision of service	Charting provision of service in a non-English language involves the person writing the chart note will enter, immediately following the service name "(Provided in [specify language])"
Example	MHS-Ind. Ther. (Provided in Vietnamese)...

Child Abuse Reporting Forms

Process

After a required child abuse report has been made, a copy of the Child Abuse reporting form will be placed in the Correspondence section of the minor's chart.

Discharge Summary

Description

The Discharge Summary describes briefly the:

- Reason for the client's treatment
- Course of treatment
- Client's condition on discharge

Which cases must have a DS

A Discharge Summary must be completed as follows:

- On all cases open more than two months
- For all cases, an ID note is written at least noting the discharge
- In cases open less than two months, this ID note should explain the above items

Timing

Discharge Summaries must be completed within the following time frames:

If...	Then...
It is unclear whether the client will return for further services	The Discharge Summary will be completed no later than six months from the last service
No further treatment is planned.	The Discharge Summary will be completed within one month of a clear termination
A client has a planned absence of somewhat more that six months, but it is planned that the client will return for further treatment and if the rationale for this is explained in the ID notes.	The chart may be kept open for longer than six months

Completing the form

The following instructions apply to completion of the Discharge Summary:

- All parts of the form must be completed
- Indicate what services are being terminated:
  - MHS
  - DTR
  - MSS, etc.
- If the client is receiving medications upon discharge, fill in the names of those medicines
- "Admission Date" is the date of entry or registration for the client
- Date of Last Documented Client Contact is the date of the last clinical service involving actual contact with the client

See "Chart Closure" section for related information.

General Report Form

Purpose

The General Report Form may be used as a formatted form for typing any report. All relevant information is filled in at the top of each page used.

Notice of Action Forms

Requirement

The following requirements apply to the receipt of Notice of Action forms:

When...	Then...
A Medi-Cal (or other Notice of Action) is given to a client, indicating a denial of services	A copy of the Notice of Action form will be placed in the chart (in the Legal section)
The chart is closed and episoded	This form will be placed in the episode according to instructions from the Medical Records Office

Advance Directives

Description

Advance directives:

- Provide instruction on how a person wants his/here future healthcare to be carried out
- Have legal standing and should be honored by all healthcare providers. when properly prepared
- May address psychiatric care as well as other healthcare areas

Requirement to notify

The State Department of Mental Health requires:

- DBH to inform adult clients upon entry about advance directives
- Those clients have the right to establish directives

Note: Advance directive notification is not required for minor clients

Where information is found

Reference to this is in the DBH Consumer Brochure, and detailed materials being developed on the subject are part of the information that all sites and providers are required to provide to clients in waiting rooms.

Use of form

The DBH Advance Directives Notice form is used to advise all providers whether or not the client has established advance directives. The following information is recorded on the form:

- If the client reports that he/she has no advance directives that will be noted in the top section of the form
- If advance directives are completed here, or if the client brings to us a copy, these will be filed with the Notice form in the chart section that contains consents for treatment
- The client may also tell us that advance directives are at another location a physicians' office, and agency etc. and that other location will be recorded on the Notice form
- Clients will be informed that they can bring a copy of current advance directives for inclusion in the DBH chart
- Additional a sections of the form will be completed if the client changes his/her advance directives or where they can be obtained

Continued on next page

Responsibility to follow advance directives

The client's advance directives will be followed in almost all cases, however use the following chart in these two situations:

If...	Then...
A provider believes that for some reason an advance directive should not be honored	Supervisors and County Counsel should be consulted
It is known that an advance directive exists, and a critical healthcare decisions must be made,	That advance directive should be consulted, whether or not it is in the DBH chart.

Authorization to Obtain Medical Care for Minor

Purpose

This form, labeled “MED. CARE AUTHORIZATION FOR MINOR,” enables a person with medical care rights regarding a minor (such as a parent or legal guardian) to authorize, in advance, DBH clinic staff to obtain medical care for the minor that should become necessary while the minor is in the care of the clinic and the parent is not available.

Example: A child falls or is cut while in a session and parents are not in the clinic.

Procedures

The following procedures apply to completion of this form:

- It is recommended that clinics have this form completed for each minor client at the time of registration and treatment consent
- Any non-parent who signs this form must produce documentation to prove their custodial and/or medical rights, just as they must do in order to be allowed to sign the treatment consents
- The form must be witnessed (with signature) by DBH staff
- Staff must take this form with them to the medical facility if they take the minor for care

Authorization to Release Confidential (Protected) Health Information

Policy

The form "Authorization to Release Confidential Protected Health Information" is used both to request information from other sources and to release DBH information regarding a client.

Completion of authorization

Following are procedures for completing the authorization:

- Make sure that the client understands what information will be released and any foreseeable consequences of the release
- Enter name of facility releasing information after "I AUTHORIZE:"
- Enter name of facility receiving information above "Facility Name."
- If possible, the name of a specific person who is to receive the information is required

If DBH is releasing information, enter the specific purpose(s) for the release (e.g., SSI application, inform client's new therapist, provide required probation reports, etc.).

Check information to be released, or describe in "Other." Only information necessary for the purpose listed above should be released. (It is very rare that an entire chart would be copied and released.

Use of authorization

An authorization, once signed, may not be used to justify future releases of information unless these are exactly the same as described in the release, are intended by the authorizing person to occur when signing the release, and occur before the expiration of the release.

The authorizing person has a right to a copy of the release. It is good practice always to give a copy to the authorizing person.

Cancellation of authorization

The client or client representative (conservator, person with medical consent rights for a minor) may cancel the release in writing at any time. If not cancelled specifically, an authorization terminates 90 days from the date of signature, or if so checked on the form, (1) on completion of the requested action, or (2) one year from the date of signature or the date the client's chart is closed, whichever comes first.

Release of health information

Protected health information (PHI) received from other sources should usually not be released by DBH to another facility. Clients are informed that DBH cannot guarantee that facilities receiving PHI from DBH will not release it themselves to other facilities. (Only alcohol and drug related PHI is legally protected from such re-release, as noted on the release form.)

Continued on next page

Signatures on release forms

The person signing the release must be the client or a person having medical consent rights for the client, such as a DCS worker or conservator. All persons besides those reasonably believed to be the parents of a minor client must provide written proof of their right to make medical decisions for the client.

Requests for PHI, once completed, will be forwarded to the current provider treating the client. The provider will sign the form (or not sign the form, if he/she wishes to deny the release based on client welfare).

Release information rules

When the protections afforded confidential/PHI information are different in California law and in HIPAA, the rule affording greater protection will be used. Thus, if HIPAA permits release but state law, as embodied in Welfare and Institutions Code 5328, does not allow it, the information will not be released. In problem situations, supervisors should be consulted.

Note: See the Department's Standard Practice Manual for rules relating to a client's request for information from his/her own chart that DBH providers do not believe is in the client's best interest.

Consent for Treatment

Description

The Outpatient Consent for Treatment explains certain conditions of treatment, including circumstances under which confidential information may be disclosed without the client's consent.

When form is signed

The form should be signed by the client or responsible guardian, conservator, etc. before the client receives professional services, if at all possible, or as soon as possible thereafter

Services in the field

When initial services are provided in the field (no clinic visit), if face-to-face contact with the person being helped occurs, then an Outpatient Consent for Treatment will be signed by the person (or other person with legal consent rights).

Minors

Consent forms are accessible in English and Spanish. Note that the following persons do not automatically have the right to consent to this treatment:

- DPSS workers
- CPS workers
- Foster parents
- Legal guardians

These persons will not be allowed to consent to treatment for minors unless they have the authorization to do so in writing.

See SPM 9 – 1.15 for details regarding who can consent to treatment for minors.

Filing written authorizations

If any person other than a parent signs for consent, his/her written authorization to do so will be placed in the chart. This includes copies of:

- Guardianship
- Conservatorship orders
- DPSS court authorizations to consent to treatment

Continued on next page

Therapy vs. medications	Note that consent for psychotherapy or counseling, for adults or for minors, does not imply consent for the use of psychotropic medications (which must have separate consent).
Conservatees	In the case of a client who is under conservatorship, the conservator must authorize all non-emergency outpatient care.
Medi-Cal	All Medi-Cal eligible clients must have their attention drawn to item 10 of the consent form, which indicates that receiving mental health services is not a prerequisite for access to other community services, and that the client may seek other providers and services when they are desired.
Witness	A Departmental representative (clerk or professional) must sign the form also, as “witness”
Filing	The form is filed in the center (middle) section of the chart, on the right hand side.
Copy for client	The client is given a copy of the signed consent form.
Consent form in another language	See Forms in other Languages section for procedures for the use of a consent form issued by Quality Management in a language other than English.

Consent to Sound or Video Record

Usage	The Consent to Sound or Video Record form will be used to document client consent for recordings of client sessions.
Purpose of recording	The specific purposes for which the recording will be used must be specified, and the date of consent expiration must be listed.
Decision to consent changes	If the client changes his or her mind and wishes to cancel the consent, this is documented on the same form.
Filing form	The form is filed along with the other treatment consents in the chart.

Medicare Advance Beneficiary Notice

Purpose

The Medicare Advance Beneficiary Notice is used to notify Medicare clients that a certain service may not or will not be reimbursable by Medicare.

Frequency

The Medicare ABN is filled out and signed by the client in advance of every service that may not or will not be reimbursable by Medicare (except that only annual notice is necessary regarding a service that is never covered by Medicare.)

Procedure

The following procedure is followed when completing the Medicare Advance Beneficiary Notice:

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1</td><td>The client’s name and Medicare number (if available) are entered at the top of the form.</td></tr>
<tr><td>2</td><td>The client is told that the service in question may not or will not be reimbursable by Medicare.
• The form is pre-printed with information about services that are not covered and the reasons why this might be so</td></tr>
<tr><td>3</td><td>In the “Items or Services” box, write the name(s) of the service(s) in question. The reason(s) each service in question may not or will not be reimbursable is (are) indicated in the “Because” box by checking the appropriate box or writing in the reason.</td></tr>
<tr><td>4</td><td>The following actions will be taken should the client ask questions at this point:</td></tr>
<tr><td></td><td><table>
<tr><th>If the client...</th><th>Then the...</th></tr>
<tr><td>Asks the potential cost of the service to himself/herself,</td><td>Estimated cost is entered in the appropriate space on the form.</td></tr>
<tr><td>Does not ask the cost</td><td>Enter “did not ask”.</td></tr>
</table></td></tr>
<tr><td>5</td><td>The client checks option 1 or 2, indicating that he/she wants or does not want to proceed with the service, and signs the form.</td></tr>
<tr><td>6</td><td>Retain the original signed form, and give a copy to the beneficiary. If the client refuses to sign but demands the service, note on the form that the client refused to sign but demanded the service.</td></tr>
</table>

Filing

The originals of the form are filed as the top paper in the “Identification” section in the back of the chart.

Medications Consent Form

When completed

The medications consent form should be completed the first time the physician prescribes medication for a client.

Completing form

The following steps in completing the Medications Consent Form:

Step	Who completes	Action
1	Physician	Gives the client the information explanations called for in the top section.
2	Physician	Signs and dates the top portion.
3	Physician	Writes in the medication name in the bottom section
4	Client	Dates and signs that line in the bottom section

Each time another medication is started, the physician gives the appropriate information (at the top) and then initials and dates on the blank line in the middle of the page, affirming that such information has been given. The client signs and dates for each new medication.

New form necessary?

Use the following table to determine if a new form is necessary:

Situation	New Form Needed?
Another physician fills in for the client's regular physician	No
A new physician takes over the case	No
A new episode is opened for the client	Yes

Discontinued meds

If a previously used but discontinued medication is started again, a new line on the form need not be completed.

Re-writing the form

There is no requirement for re-writing the form based solely on how long a form has been used.

Form in another language

See Forms in Another Language section for procedures for use of a Medications Consent Form issued by Quality Management in a language other than English.

Telepsychiatry Consent

Purpose

The DBH Telepsychiatry Consent form will be used, in addition to the regular Outpatient Consent Form, whenever telehealth/telemedicine services are provided.

Treatment Consent Delegation

Purpose

In some cases, parents or other persons with medical consent rights for a child may be unable to come to a clinic to consent to treatment for the child.

- Also see SPM 9 – 1.15 for other parameters regarding consent in cases of minors

Procedure

The following rules apply to completion of the Treatment Consent Delegation:

- This form may only be used if the parent is physically unable to be present, because of being:
  - Housebound,
  - Incarcerated, etc.
- It may not be used to gain consent in case in which parents are simply uninterested or unwilling to come
- The signature of a witness who observes the parent or other delegating person sign the form must be included
- The person receiving treatment consent delegation must show, in addition to the delegation form, a copy of an ID showing the delegating person's signature so that we may affirm that the signature on the delegation form is genuine
  - This ID copy is filled in the chart with the delegation form, in the place where other consent forms are filed.
- The back (or second page) of the form should be used by the delegating parent or other person to give information about the child's recent medical care

Confidential Record Release within County without Client Authorization

When the client files a lawsuit

When a client files a lawsuit against the Department or the County for personal injuries, the State's Evidence Code and Civil Code provide that those accused have access to the client's recorded of care.

Client consent to access

This access to client records may be without client consent or knowledge. When there is no client consent:

If the chart is...	Then The Confidential Record Release within County without Client Authorization form will be filled out and filed in the chart by the...
Open	Clinic Clerk
Closed	Central Medical Records

Request for Release of Confidential Information to the Patient's Rights Advocate Office

Patient's Rights Advocates access

In the appropriate discharge of their duties, patient's rights advocates need access from time to time to client charts, either for:

- Investigation of possible rights violations, or
- Required monitoring of client's rights in facilities.

Client signature

When the client is available to sign a release of information form for these uses of the record, this will be accomplished. However, access to client records may be without client knowledge or overt consent in some instances, and in those instances the self-explanatory form (title above) will be filled out by the advocate and filed as follows:

If there is...	Then the form will be entered in the chart by...
An open chart,	The record clerk of the clinic.
A closed chart,	Central Medical Records.

Letters "To Whom It May Concern" Requested by Clients

Purpose

From time to time clients may request that staff provide them with letters "to whom it may concern" which the clients can take with them and show to whomever they wish.

Use by clients

Clients may wish to use such letters as:

- Introductions to future treatment personnel, or
- Proof to an agency that they have received services, or
- Confirmation of a certain diagnosis, etc.

General policy

In general, in accordance with the regulations of Title 22, such letter **should not be provided**. The reason for this is the concern that the client may give the information to someone who:

- Will use it to harm the client, or
- Is not bound by the regulations which prohibit re-release of the information to another party.

Requests from future treatment personnel

Any need of future treatment personnel for records should be met by a request from those personnel to DMH for the records, with a proper release from the client.

Justifiable exception

If there seems to be a justifiable exception to the above prohibition, then the purposes for which the client anticipates using the letter should be carefully discussed with the client, to make sure that such use:

- Would be in the client's best interest, and
- That the client is not intending to use the information in a deceptive or inappropriate way.

Exception procedure

If it is decided that such an exception exists and that a letter is to be provided then the following procedure applies:

Step	Action
1	Release of information form should be signed by the client.
2	Details of the anticipated uses of the letter must be provided.
3	Release of information form is given to the client.

Continued on next page

Letters “To Whom It May Concern” Requested by Clients,
Continued

Facts vs. opinions

In general, such letters should confine themselves to the facts of a client’s care in this department. The more the letters depart from the facts and go into areas of opinion or speculation, the more likely it is that the information could be misused.

Approval

All “To Whom it May Concern” letters must be reviewed by the Clinic Supervisor for appropriateness.

If the Clinic Supervisor...	Then he/she will...
Approves,	Initial the letter
Does not approve,	Not release the letter

Required paragraph

All “To Whom it May Concern“ Letters will contain the following paragraph:

Any person receiving this letter should note that California Title 22 regulations prohibit him/her from giving this letter or a copy of this letter to anyone else, or informing anyone else of any of the information contained in this letter, without the client’s specific written permission. Furthermore, the person about whom this letter is written (or his/her legal guardian or parent) has been informed that in giving this letter to anyone, he/she assumes a certain risk regarding the future safeguarding of the information.

Release at a later date

“To Whom it May Concern” letters should never be released at later times to any other parties, without the client’s specific consent.

Abbreviation List

POLICY: Only abbreviations in the Department's officially approved list of abbreviations (to follow) may be used in DBH charts. (Programs or individuals wishing to add abbreviations to the list may submit them to the Quality Management for consideration. Consideration will be made on the basis of clarity and non-ambiguity.)

Continued on next page

Abbreviations

The following list shows common abbreviations used in this handbook as revised on March 1, 2004.

Abbreviation	Description
AA	Alcoholics Anonymous
AB2726	School Referred SED Children for State Program
ABC	Augmented Board and Care Homes
ABPP	American Board of Professional Psychology
ACOA	Adult Child(ren) of Alcoholics
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
ADL	Activities of Daily Living
admin.	administration
Adol.	Adolescent
ad.-bro.	adoptive brother
ad.-dau.	adoptive daughter
ad-â / ad.-fa.	adoptive father
ad.-M / ad.-mo.	adoptive mother
ad.-sis.	adoptive sister
ad.-son	adoptive son
â/fa.	father
ADS	DBH Div. of Alcohol and Drug Services
A/H	Auditory hallucinations
AIDS	Acquired Immune Deficiency Syndrome
AKA	Also known as
A.M.	Ante Meridiem = morning
AMA	Against Medical Advice
AMAC	Adults Molested as Children
approx.	approximately
appt.	appointment
APS	Adult Protective Services
ARMC	Arrowhead Regional Medical Center
ARMC-BH	Arrowhead Regional Medical Center – Behavioral Health
ARTS	Adult Residential Treatment System
ASAP	As soon as possible
ASI	Addiction Severity Index
assess.	assessment
assoc.	association
asst.	assistant
A/V/H	Auditory and Visual hallucinations
AWOL	Absent without leave

Continued on next page

Abbreviations, continued

B.A.	Bachelor of Arts
BAL	Blood Alcohol Level
Basis-32	Behavior and Symptom Identification Scale
B&C	Board & Care
BCD	Board Certified Diplomate (Social Work)
B/F	Boyfriend
BFCS	Bilingual Family Counseling Services
BHRC	Behavioral Health Resource Center
BIB	Brought in by
B.I.D.	Twice a day (Latin - bis in die)
BM	Bowel movement
BP	Blood Pressure
bro.	brother
B.S.	Bachelor of Science
BUN	Blood Urea Nitrogen
CalWORKS	CalWORKS
CAFAS	Child and Adolescent Functional Assessment Scale
CA-QOL	California Quality of Life Scale
canc.	cancelled
cap	capsules
CARF	Committee on Accreditation of Rehabilitation Facilities
CARS	Child Assessment Referral Services
CDSB	Casa de San Bernardino
CBC	Complete Blood Count
CBCL	Child Behavior Checklist
CCC	Community Client Contact
CCICMS	Centralized Children's Intensive Case Management Services
CD	Chemically dependent
CERT	Fourteen day certification
CFE	Community Functioning Evaluation
CHF	Congestive heart failure
CID	Center for Individuals w/Disabilities
Cl., cl.	Client
Cl. Pl.	Client Plan
CLEP	Client Living Environmental Profile
clin.	clinician
Clin.Th.	Clinical Therapist
C&L	Consultation and Liasion

Continued on next page

Abbreviations, continued

CM	Case Management
C.Mgr	Case Manager
CMDC	Chino Multiple Diagnosis Clinic
CNS	Central Nervous System
CODA	Codependents Anonymous
coll.	Collateral
conj.	Conjoint
CONREP	Conditional Release Program
CONS	Conservatorship
Consult	Consultation
cont.	continued
COTA	Certified Occupational Therapy Assistant
CPS	Child Protective Services
CSQ-8	Client Satisfaction Questionnaire
CSOC	Children's System of Care
CSOC-TAT	CSOC Technical Assistance Team
CSW Int.	Clinical Social Worker Intern
CT Scan	Computerized Tomography Scan
CYA	California Youth Authority
CWIC	Crisis Walk-In Clinic
dau.	daughter
day tx	day treatment
DAAS	Department of Aging and Adult Services
DBH	Department of Behavioral Health (San Bernardino)
D/C	Discharge, discontinue
DCS	Department of Children's Services
DD	Developmentally Disabled
DDX	Differential diagnosis
dept.	department
Des/Mtn	Desert/mountain region
DPG	Deputy Public Guardian
Dr.	Doctor
DR	Department of Vocational Rehabilitation
DIP	Drunk in Public
DSM-IV	Diagnostic & Statistical Manual (4th Edition)
DTI	Day Treatment Intensive
DTO	Danger to Others
DTR	Day Treatment Rehabilitative
DT's	Delirium Tremens
DTS	Danger to self
DUI	Driving under the Influence

Continued on next page

Abbreviations, continued

DWI	Driving While Intoxicated
DX	Diagnosis
ECT	Electroconvulsive therapy
EEG	Electroencephalogram
e.g.	exempli gratia = for example
EKG	Electrocardiogram
empl.	employment
EPS	Extra Pyramidal Symptoms
ESPDT	Early Periodic Screening Diagnosis & Treatment
E.R.	Emergency Room
esp.	especially
etc.	et cetera
ETOH	alcohol
eval.	evaluation
EVRC	East Valley Recovery Center (previously Phoenix)
ex-hus.	ex-husband
EYH	Enriched Youth Home
ex-wife	ex-wife
fam.	family
F.I.	Financial Interviewers
fos.-bro.	foster brother
fos.-dau.	foster daughter
fos.-hm.	foster home
fos.- â / fos.-fa.	foster father
fos.-Ⓜfos.-mo.	foster mother
fos.-sis	foster sister
fos.-son	foster son
ft	feet
FYI	For your information
GA	Gamblers Anonymous
GAF	Global Assessment of Functioning Scale
GD	Gravely disabled
G/F	Girlfriend
G.I.	Gastrointestinal
gr.-dau.	granddaughter
gr.- â / gr.-fa.	grandfather
gr.-Ⓜ/ gr.-mo	grandmother
gr.-son	grandson
grp	group
grp. hm./GRH	group home

Continued on next page

Abbreviations, continued

HCG	Human Chorionic Gonadotropin test
H.F.	Healthy Families Program
H/I	Homicidal Ideation
HIV	Human Immunodeficiency Virus
Hom. Id.	Homicidal Ideation
hosp.	hospital
hr	hour
H.S.	Bedtime, hour of sleep
ht.	height
hus.	husband
hx	history
IA	Interim Assistance
IBHS	Inland Behavioral Health Services
ICD-9-CM	Int'l Class. of Diseases-9-Clinical Modification
ICD-10	Int'l Class. Of Diseases-10
ID Notes	Interdisciplinary notes
IDU	Injecting drug user
i.e	That is
IEHP	Inland Empire Health Plan
IFP	Intensive Family Preservation Program
IM	Intramuscularly
IMD	Institute for Mental Disease
in	inch
incl.	including
ind	individual
IQ	Intelligence Quotient
IRC	Inland Regional Center
IV	Intravenous
IVDA	Intravenous drug abuse
IVDU	Intravenous drug user
JCAHO	Joint Commission on Accreditation of Hospital Orgs.
JESD	Jobs and Employment Services Department
JETS	Juvenile Evaluation and Treatment Services (W.V. Juv. Hall)
JJOP	Juvenile Justice Outpatient Program (E.V. Juvenile Hall)
JMHS	Jail Mental Health Services
L&C	Linkage & Consultation
LCSW	Licensed Clinical Social Worker
LFT	Liver function test
lg	large
LLBMC	Loma Linda Behavioral Medicine Center

Continued on next page

Abbreviations, continued

LLUMC	Loma Linda University Medical Center
LMFT	Licensed MFT
LNMP	Last normal menstrual period
LOC	Location
LPS	Lanterman-Petris-Short Act
LPT	Licensed Psychiatric Technician
LT	Long term
LTO	Locked Time Out
LVN	Licensed Vocational Nurse
M.A.	Master of Arts
mat.-gr. â / mat.-gr.-fa.	maternal grandfather
mat.-gr. Ⓜ/ mat.-gr.-mo.	maternal grandmother
max.	maximum or maximize
MBMH	Morongo Basin Mental Health
mcg	Microgram
M/Cal	Medi-Cal
M/Care	Medicare
M.D.	Medical Doctor
MDT	Multi-Disciplinary Treatment Team
meds	medication
METRO	Metropolitan State Hospital (Norwalk)
MFT	Marriage & Family Therapist
mg	milligrams
mgr	manager
MHCI,II,III,IV	Mental Health Clinician I, II, III, IV
M.H.S	Mental Health Specialist
MHS	Mental Health Services
MHSIP	Mental Health Statistics Improvement Program Consumer Survey
MIA	Medically Indigent Adult
mins.	minutes
MJ	Marijuana
Ⓜ/mo	Mother
MR	Mental Retardation
MRI	Magnetic Resonance Imaging
M.S.	Master of Science
M.S.W.	Master of Social Work
mtg.	meeting
NA	Narcotics Anonymous

Continued on next page

Abbreviations, continued

N/A	Not Applicable
NAPA	Napa State Hospital
N/B	Non-Billable
neg.	Negative
NHIC	National Heritage Insurance Company (Medicare)
NKA	No Known Allergy
no.	Numero = Number
noc	Night
NPS	Non-Public school
NVS	North Valley School
OA	Overeaters Anonymous
occas.	occasional(ly)
1:1	Individual therapy
OT	Occupational Therapist
OTR	Registered Occupational Therapist
outpt.	outpatient
O/V	Office Visit
$\overline{p}$	After
pat.-gr. â/pat.-gr.fa.	paternal grandfather
pat.-gr. Ⓜ/ pat.-gr.-mo.	paternal grandmother
P.C.	Penal Code
P.D.	Police Department
PDD	Pervasive Developmental Disorder
PET	Psychiatric Evaluation Team
PET SCAN	Positron Emission Tomography Scan
Ph.D.	Doctor of Philosophy (psychology)
PHF	Psychiatric Health Facility
PL	Placement
Pl.Dev.	Plan Development
pl. ther.	Play therapy
P.M.	Post Meridiem = after noon
PMS	Premenstrual Syndrome
po	oral
POE	Proof of Eligibility
POR	Problem Oriented Record
pos.	positive
PP	parent partner
prn	Pro re nata = whenever necessary, as needed
prob.	problem

Continued on next page

Abbreviations, continued

PSH	Patton State Hospital
Psych Triage	Psychiatric Triage (ARMC)
Psy.D.	Doctor of Psychology
P.T.	Psychiatric Technician
pt.	patient
pta	prior to admission
PTSD	Post Traumatic Stress Disorder
Pub. cons	Public Conservator
Pvt. cons	Private Conservator
Pvt. M.D.	Private Medical Doctor
Px	Prognosis
q	every
QID	Four times a day
R&B	Room and board
RCC	Redlands Counseling Center
RCCS	Rancho Cucamonga Counseling Services
RCH	Redlands Community Hospital
RCL	Rate Classification Level
re	regarding
rec'd.	received
reg. Ed.	regular education
rel-shp.	relationship
ret.	return
RFT	Renal Function Test
RGH	Riverside General Hospital
RN	Registered Nurse
R/O	Rule Out
ROWE	Reach Out West End
Rpt.	Reports
RSP	Resource Specialist Educational Program
RTC	Return to clinic
RWD	Recovery, Wellness, and Discovery
Rx	Prescription
2nd CERT	Second 14 day certification
St. B's	St. Bernardine's Hospital
SACH	San Antonio Community Hospital
SARB	School Attendance Review Board
SBCDPH	San Bernardino County Department of Public Health
SBCH	San Bernardino Community Hospital
sc	Subcutaneous
schiz.	Schizophrenia or schizophrenic

Continued on next page

Abbreviations, continued

SDC	Special Day Class
SDC	Special Day Class
SDI	State Disability Income
SED	Seriously Emotionally Disturbed
SELPA	Special Education Local Plan Area
SHAC	Shandin Hills Adolescent Center
S/I	Suicidal Ideation
sib.	sibling
SIR	Special Incident Report (Children in placement only)
sis.	sister
sm.	small
SMA	Serum Metabolic Analysis
SMI	Seriously Mentally Ill
SNF	Skilled Nursing Facility
S.O.	Significant Other
SP	Suicide precautions
Sp.	Spanish
SPAN	San Bernardino Partners Aftercare Network Program
SPMI	Seriously and persistently mentally ill
S&R	Seclusion & restraint
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
SSRI	Selective Serotonin Re-uptake Inhibitor
ST	Short term
STAR	Supervised Treatment After Release
STAR-LITE	STAR - Less Intensive Treatment Environment
STAT	Immediately
STEP	Systematic Training for Effective Parenting
st.-bro.	step-brother
st.-dau.	step-daughter
st.- â / st.-fa.	step-father
st.-gr. Ⓜ / st.-gr.-mo.	step-grandmother
st. Ⓜ - / st.-mo	step-mother
st.-sis.	step-sister
st.-son	step-son
Svc.	service
Sx	symptoms
tab.	Tablet

Continued on next page

Abbreviations, continued

TAD-ESP	Transitional Assistance Department--Employment Services Program
TANF	Temporary Assistance for Needy Families
T.B.	Tuberculosis; tubercle bacilli
TBS	Therapeutic Behavioral Services
T/C	Telephone Call
TCON	Temporary Conservatorship
TD	Tardive Dyskinesia
TFT	Thyroid function test
ther.	therapy
thru	through
T.I.D	three times a day
thru.	through
T.I.D.	Three times a day
trng.	training
tx	treatment
tx. pl.	treatment plan
tx. pl. conf.	treatment plan conference
tx. tm.	treatment team
UBH	United Behavioral Health
UCCC	Upland Community Counseling Center
UDS	Urine drug screen
unk.	unknown
UR	Utilization Review
U/A	Urinalysis
V.A.	Veterans Administration
VDRL	Venereal Disease Research Laboratory
V/H	Visual hallucinations
Voc. Rehab.	Department of Vocational Rehabilitation (see DR)
VOL	Voluntary
w/ or c	with
WBC	White blood cells (white blood cell count)
W&I	Welfare and Institutions
w/in	Within
wk	week
W/o or s	Without
WNL	Within Normal Limits
WRIT	Writ of Habeas Corpus
Wt.	Weight
WVDC	West Valley Detention Center
y/o	year old

Continued on next page

Abbreviations, continued

yr.	year
YSR	Youth Self Report
½ bro.	Half-brother
½ sis.	Half-sister
1N	Primary
2N	Secondary
5150	72-hour evaluation for adults (mental illness)
5170	72-hour evaluation for persons inebriated
5250	14-day certification hold
5585.5	72-hour detention-section 5150 of W&I for minors
c	with
L	Left
R	Right
s	without
i	One tablet
ii	Two tablets
8	Increase
9	Decrease
	None
#	Number
	Plus or positive
	Negative
&	And
@	At
&	Female
%	Male
o 2	Secondary to

Co-Signatures

Co-signatures required	All of the following non-regular employee interns will have all billable chart entries co-signed by an appropriate supervisor : • Volunteers • Community Service Aides **Note:** In the case of interns, this supervisor must be licensed.
Not included	This is not required for MFT post-degree “interns” who are DBH employees.
Other entries	Other types of entries may be signed as well, if desired.
Non-licensed OT’s	Non-licensed OT’s will have all billable chart entries co-signed until licensure is achieved, and COTA’s will have all billable chart entries co-signed by an appropriate supervisor during the first year of DBH employment.
ID notes written by clerks	Clinic Supervisors (or designees) will co-sign administrative chart closure ID notes written by clerks.

Corrections

Making chart corrections

Correcting items written or typed in the chart is done by:

- Drawing a single line through the material deleted
- Writing the replacement material next to it, with the word “error”
- Initialing the change

Example of correction

An example of appropriate correction is:

- ~~touched~~ fondled
  error cee

White out

“White out” or other means of correction should never be used in the chart.

Legibility

Policy

Everything handwritten in the chart must be legible because it:

- Is useful for other clinical staff
- Can be read by auditors

Auditors

Auditors may disallow payment for services for which documentation is unreadable.

Medication Support Services ID Notes – Ink Usage

Type of ink used

Only black and blue ball-point ink will be used in the chart in order to:

- Minimize potential water damage
- Maximize copy quality for copying and microfilming

Persons Allowed to Chart

Restricted charting

Charting of the following items In outpatient charts may only be done by the assigned provider for the service or chart at issue:

- Services
- No-Shows
- Rescheduling
- Chart Closure

Assigned providers

The following persons are considered assigned providers:

- Clinical therapist
- Non-staff intern
- Physician
- Clinical volunteer
- Mental Health Specialist
- Nurse
- Psych Tech

Day treatment intensive charts

In day treatment intensive charts, only persons assigned to do so by the Clinic Supervisor or day treatment coordinator may write DTI daily or weekly summaries.

Weekly summaries

Weekly summaries must be written by or co-signed by an LPHA who is an:

- M.D.
- RN.
- Licensed registered, or waivered clinician
- And who is DTI staff or director of the program

Other staff

Other staff who might write notes for co-signature would include:

- O.T.’s
- Non-staff interns
- Mental Health Specialists
- Psych Techs

Continued on next page

Day Treatment Rehab Weekly Summaries

In day treatment rehabilitative charts, only persons assigned to do so by the clinic Supervisor or day treatment coordinator may write DTR daily or weekly summaries. Staff who could write notes without co-signatures are LPHA's:

- M.D.
- R.N.
- Licensed, registered or waivered clinician
- Psych Techs
- Non-staff interns

Other staff

Other staff who might write notes for co-signature would included:

- O.T.
- Mental Health Specialist

Signatures

General requirements

All signatures in the chart must be legible. In order to ensure legibility, the signer will print (or stamp) his/her name and title as shown in the table below. Signatures will be made with the following formats:

Staff	Signature
Physician	John Smith, M.D.
Psychologists	John Smith, Ph.D.
Licensed Clinical Social Workers and Licensed MFT's	John Smith, M.S.W, LCSW, or John Smith, LCSW John Smith, M.A., MFT, or John Smith, MFT
Unlicensed Social Workers and Unlicensed MFT's	John Smith, M.S.W, ASW or John Smith, ASW John Smith, M.A., MFT Intern John Smith, MFT Intern
Registered Occupational Therapists	John Smith, O.T.R.
Non-registered Occupational Therapists	John Smith, O.T.
Licensed Psychiatric Technicians	John Smith, P.T. or John Smith, L.P.T
Non-licensed Psychiatric Technicians	John Smith, Psy.A. (for Psych Aide)
Non-staff Interns	John Smith, M.A., Psychology Intern John Smith, B.S.W., Social Work Intern John Smith, B.A. MFT Trainee John Smith, O.T. Intern
Others	John Smith, (degree if any), volunteer John Smith (degree if any), County Classification

Time Units

How billing is done

Billing is done by the minute. Any number of minutes can be billed in SIMON. Bear in mind, however, that it costs the Department about four dollars to bill a service, and the current Medi-Cal reimbursement rate is around two dollars per minute.

Activities of Clerks

Not billable

Interactions of clerical staff with clients are never billable as Medi-Cal services.

Assessment

No limit	There is no longer a limit on the number of assessment billings per episode.

Auditing

Requirements

Time for supervision on a case or for audits is not billable as a client service or as Plan Development. If auditing results in a chart note indicating a change in the services plan or direction of treatment, then the time is billable.

Before Client Contact

Requirements

Billing always requires:

- An open treatment episode
- Client consent (or implied consent)

Services before contact

Given these requirements, services performed before the first client face-to-face contact with clinical staff is possible if the service meets the definition of a defined billing category

Common billable categories

The most likely categories to be billable under these circumstances are:

- MHS-PL.Dev.
- MHS-Coll.
- CM-L&C. CM-Pl.
- CM-L&C-Pl.Dev.

Services always requiring contact

The following services would always require client contact:

- MHS-Ass.
- MHS –Eval

Case Management Plan Development

Coding

The State Rehab manual lists Case Management Plan development as part of Linkage and Consultations. CM Plan Development notes are therefore headed “CM-L&C-Pl.Dev.” and “CM-L&C-Pl. Dev. is billed using the CDI code for L&C (561). CDI code 521 is for MHS Plan Development only.

Chart Closure

Billing chart closure

The billable service involved in chart closure is Plan Development, in the form of:

- Treatment planning
- Monitoring of client progress
- The following service can therefore be billed as Plan Development by clinical staff
  - Discussions regarding the decision to terminate a service, as can
  - Charting the final ID note and
  - Filling out the discharge summary, as long as the summary contains some legitimate Plan Development.

Follow-up care

The following applies to billing for follow-up care:

If...	Then...
You have planned some follow-up care with the client or are making a referral upon termination, and you record this in the discharge summary	It is billable.
You are doing a “true” termination with a client, and you decide with the client that no further treatment is needed, and you record that on the discharge summary,	It is billable
if the client “disappears” and you try to contact him/her, but fail, and you fill out the discharge summary, since there is not planning or monitoring that can be done,	Filling out the discharge summary is not billable.

Last session and discharge summary

It is preferable that the time for filling out the discharge summary be lumped together with the last client session. Just as other charting is combined with session time for billing purposes. If this is not possible, and a discharge summary is filled out later, a separate plan development billing can be made.

Combining Service, Charting, and Plan Development Time

Example

Charting time and minor plan development time occurring before, after, or during the service can be lumped in with the service as one charge.

An example of charting minor plan development time after the service is as follows:

If the...	Then the...
Service was 50 minutes, the charting time for that session was10 minutes, and you spent 5 minutes altering a milestone at the same time,	Billing should be for 1:05 (one hour and five minutes).

Minor and major plan development

The following chart contains information about minor and major plan development:

Note: There is no billing for Plan Development allowed for Day Treatment services.

Type of Plan Development	Chart and Billing Procedure
Minor activities might involve minor revision of a Client Plan or planning with co-staff a particular or changed treatment approach to be used in the upcoming session ID note	Can be combined with a treatment billing.
Major activities, such as a team meeting or completely filling out treatment planning forms	Should be separately charted and billed.

Crisis Intervention

Billable time

Consecutive crisis interventions can be billed (for up to an eight-hour total per day), as long as each note reflects that the crisis intervention was necessary and appropriate.

Daily Limits

Limit for billing	A clinician cannot bill for more minutes in one day than he/she works.

Day Treatment

General

Day treatment is an all-inclusive service, meaning that:

- Staff cannot bill any day treatment time separately from the day treatment daily charge, including Plan Development
- Similarly, one cannot bill any time to day treatment for an activity, which occurs outside the scheduled day treatment day

Plan Development

Staff doing necessary Plan Development regarding day treatment services cannot bill those specific minutes separately from the daily day treatment charge.

Field Trips

Field trips occurring outside the normal day treatment half-day cannot be billed to day treatment. If during that outing time a necessary service occurred for a specific client, like crisis intervention, that service could be billed. (Also see outings below).

Assessment

Assessment performed with regards to day treatment can be billed as follows:

If Assessment performed …	**Then…**
After the individual becomes a day treatment client it is considered part of the daily charge for day treatment, and	It cannot be separately billed.
Before the person is a day treatment client,	It can be billed.

Evaluation

Term no longer required	This term refers only to the Community Functioning Evaluation, which is no longer required.

Groups

General

This section covers psychotherapy, Rehab/ADL, and Medication. The basic procedure is as follows:

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1</td><td>Billed time for groups is the sum of the:

• Group time
• Charting time for all charting done by that person on group clients
• Associated, minor plan development time spent by that person on all group clients</td></tr>
<tr><td>2</td><td>Group size is also indicated. For a group of six clients seen for 90 minutes by two staff time would be billed as follows:
<table>
<tr><th>Therapist</th><th>Work</th><th>Time Billed</th></tr>
<tr><td>A</td><td>Assuming that Therapist A spent a total of 30 minutes in charting and 10 minutes in plan development,</td><td>Therapist A’s time would be 2:10 (90 +30+10 =130 minutes=2 hours and 10 minutes or 2:10</td></tr>
<tr><td>B</td><td>In group 90 minutes and spent a total of 20 minutes charting and 5 minutes in plan development</td><td>Therapist B’s time would be 1:55 (90+30+5=115) 115, or 1:55</td></tr>
</table></td></tr>
<tr><td>3</td><td>In the column for “Hrs.: Min.” on the ID note form, the times for all staff are listed, using their initials, plus (C=) the total number of clients that were in the group in the above example, the “Hrs.: Min.” column would contain:

• CE = 2.10
• BB = 1:55
• C = 6</td></tr>
<tr><td>4</td><td>The same numbers are listed on all of the chart notes therapist A writes, regardless of how much attention any given client received in group or how much time was spent on that individual chart. Significant amounts of time that a client was out for any of the following reasons would be subtracted from that client’s time only:

• Late
• Left early
• Was taken out of group for some other purpose</td></tr>
<tr><td>5</td><td>If there was only one therapist in this example his initials can be omitted-i.e. 2:10
C=6</td></tr>
</table>

Continued on next page

General (continued)

Step	Action	
6	Do not add the times of therapist A and B together and enter that total anywhere.	
7	CDI. Continuing our example, on one CDI, all six clients for the group are listed. For billing purposes, it does not matter who is primary staff and who is co-staff.	
	Therapist A	**Therapist B**
	Enters the same 2:10 for all of the group clients, in the Duration or Primary Staff Time column.	Enters 1:55 for all of the group clients, in the Co—staff column. (See example CDI below)

CDI's for more than three staff

The following considerations are made when there are three or more staff:

- Since SIMON can only register two therapists per service, a third therapist would follow the same time reporting method, but would submit his/her time on a separate CDI, listing his/her total time for all group clients, with the same total group count that is on the first CDI
- A third and fourth therapist could submit their time together on the additional CDI as staff and co-staff, etc.

Late clients

If a client is not present for a significant portion of the group, the time missed is subtracted from the billing for that one client. Time missed can be attributed to:

- Being late
- Being taken out of the group to see the M.D., etc.

Example for late clients

In the example above, if one client was 30 minutes late, then his chart note and CDI line would have:

- 1:40 (instead of 2:10) for primary staff
- 1:25 (instead of 1:55) for co-staff
- All other client's chart notes and CDI lines would still be as described above

Clients out of group for meds visit

In this situation, subtract the time the client is out of the group from what his/her billed time would have been had he/she been in the group the whole time (just as if the client had been late, above.)

Continued on next page

Applicability method

This method of notating billed time for groups is applicable for all services that accept a SIMON group billing.

Contract agencies

Contract agencies bill only Medi-Cal clients but enter the actual group count: Medi-Cal clients plus other clients.

Medications support groups

Only the following persons can bill for Medication Support Services provided in a group:

- M.D.'s
- R.N's
- Psych. Tech's

The method of identifying group session time on the ID note and CDI above is applicable to ALL Groups, including MSS groups.

Medications education groups

Medications education can be provided either under:

- Medication Support Services
  - Billed as MSS-Meds. Ed. Group
- Rehab ADL in MHS
  - Billed as Rehab/ADL – Meds Ed Group

Who can bill

The following factors must be considered when billing for medications education groups:

- Only M.D.'s R.N. and Psych Techs can bill MSS
- Clinicians can only bill for medications education under Rehab/ADL
- If Alternatively

If...	Then...
A physician and a clinician do a medications education group together,	It can be billed as Rehab/ADL with one chart note and using one CDI. OR, Alternatively, the: • Physician could bill MSS and chart on all clients • Clinician could bill Rehab/ADL (and chart on all clients.) • The two of them would turn in separate CDI's billing all clients and using the total group count on both CDI's

Continued on next page

Groups with psychotherapy and MSS

If...	Then…
A clinician and a physician are both present for the entire group time in a group involving some medications support and some psychotherapy	The time would be divided between MHS and MSS.
Within a 60 minute group, the physician was doing Medication Support Services in the group with various clients for 50 minutes (not taking clients out of the group for MSS services	The clinician would bill each client for: • 10 minutes of MHS group therapy plus • All charting time • Plus all plan development time for that MHS service The physician: • Can be included as co-therapist for that 10 minutes of therapy (if present) • Would bill a 50 minute MSS group as the only staff present

Multi-family groups

For this type of group, follow the procedure outlined in Parenting Groups section below.

Parenting groups

Parenting groups may sometimes consist of some parents without their own charts who have children with charts, plus some parents who have their own charts but who do not have children with charts.

If...	Then…
A parent in this group does not have a chart but has a child with a chart	The child is billed for collateral time: • The time spent on him/her in group plus • Charting plus • Plan development for that chart only
The remaining parents do have their own charts	They are billed for group for the remaining time.

Continued on next page

Computing billable time

The sum of the actual collateral time in group (without charting or plan development) is subtracted from the group time and the remainder is used for group billing.

Example

For example, in a group of two parents without charts (but who had children with charts) and three who had their own charts

If...	Then...
The group time were 60 minutes,	• The charting and plan development time for the three with their own charts 15 minutes • The collateral time spent in group on the two without charts 6 and 7 minutes, respectively • Their charting and plan development time 5 and 8 minutes, respectively, you would make two collateral billing, for 11 minutes (6+5) and 15 minutes (7+8) and three group billings for 1:02 (60-13+15) reported with a group count of 3 • Note that the group count is only the number of parents with charts and not the total number or parents
There is only one parent with his/her own chart (who does not have a child with a chart)	He/she will be billed for : • “MHS-Ind.” (rather than for group with a group count of 1), of the time spent in-group specifically on him/her • Charting and minor plan development for that chart only

Parent and children with charts

Parents who have their own charts and also have children with charts could be billed either way.

Interpreter Services

Who may bill interpreting	Interpreter services are not billable by clinical staff. Clerical staff may bill interpreting under any appropriate MAA category.

Lockouts

Reference

See the attached State Manual Lockouts chart for services that cannot be billed for that session on the CDI.

MSS-PL. DEV. by Non-Qualified Person

Not eligible to bill

If a person not qualified to perform medication services writes part of a Client Plan for MSS services, that person cannot bill for that work due to being not qualified for that service.

Multiple Staff

Multiple staff providing service

Service other than group may also be provided by multiple staff and billed using the staff/co-staff columns on the CDI. There would be one ID note, including the names and disciplines of all co-staff and why they were present. Notation of each staff's time on the ID note page, using their initials, is done as explained under group billing.

Occupational Therapy

General

OT's and non-OT's can be mixed as staff and co-staff on any of the CDI's, but see the Department's Billing and Scope of Services document for the scope of practice all persons billing.

Outings

General

Field trips, camping trips, and other outings may include billable time if they provide:

- Life skills training (rehab/ADL individual or group)
- A milieu in which therapeutic issued are addressed directly with an individual client (individual therapy) or with groups of clients (group therapy)

Services

In order to bill for Mental Health Services for outing with outpatient clients or for outings with day treatment clients taking place outside the normal day treatment day, there must be an approved Mental Health Services service plan in place for each client billed, with objectives to which the outing relevant.

Charting

The following elements are essential in charting outings:

- An outing may not be charted as if it were one long group for all clients present
- Only the time spent in an actual, defined billable activity is billable
- Clients participating in an activity group who are doing separate projects (leather, art, etc) must be billed as rehab/ADL ind. and not group, because there was no group activity
- Clients on an outing what are each doing their separate “thing” are not participating in a group for those minutes
- Each separate service and billing (individual therapy, rehab/ADL group etc.) for each separate client must have its’ own separate chart note explaining what was done during the service in attempting to further the client’s progress toward the objectives

Audit considerations

Auditors will be looking especially closely at the need for day treatment clients to receive additional Mental Health Services. In charting, to the extent possible, staff should indicate separately therapeutic activities or issues that occurred during the transportation

Billing

Outings with day treatment clients conducted within the day treatment day are not separately billed. Outing billing will usually be for:

- Rehab/ADL group
- In some cases, rehab ADL Ind.
- Although psychotherapy services may also be provided during outings if done by qualified staff.
- If multiple services are billed for any given client, care must be taken that the billing times do not overlap (‘double-billing”).

Continued on next page

How much time may be billed

The total outing time may be billed, although times during which staff was not engaged in therapeutic activities should be subtracted from the total time before billing. These activities include:

- Meal times
- Break time
- Sleeping
- Time just watching or not interacting with clients
- Non-therapeutic portions of the transportation time

Times billed by each staff

The times billed by each staff member for the outing may be different. Since eight hours are assumed for sleep, each staff can bill for a maximum of 16 hours per day. Additionally, any time on an outing for which staff is not being compensated cannot be billed to Medi-Cal.

Staff per group

Because SIMON still not accept more that two staff per group billing, outing groups may be broken up into smaller units, each in the charge of two staff, multiple CDI's may be used as in a previous section.

If...	Then...
Clients from different programs are mixed together for an outing,	They are separated by program for billing, but the total group size of the group (or sub-group) of which they were a part is used as the group count (including all clients from all programs who were in that group or subgroup), even if that is larger than the number of clients billed on that particular CDI.

Preparation for Treatment

Non-billable time

Time spent in the following activities are not billable as client services or as plan development:

- Finding a treatment space
- Procuring or preparing materials to be used in treatment
- Arranging for co-staff participation in treatment, etc.

Psychological Testing

Process

All of the following activities are billed to the code for psychological testing:

- Test administration
- Scoring
- Test interpretation
- Report writing time

Limits

There is no limit on the number of:

- Assessments for a client
- Separate billing for a given testing episode

Chart Notes

Each separate billing (one for the administration, the next day for the scoring, etc.) must have a separate chart note indicating what was done.

Reports Outside the Department

Billing when other agencies involved

The following provisions apply to billing when other agencies are involved:

- Linkage and Consultation may be used to link clients with needed services, including mental health and other social services
- Plan Development covers only activities relating to the planning and coordination of the mental health services themselves.

Non-Billable

Reports that are filled out or written for the benefit of a third party (not the Medi-Cal beneficiary) are not billable to Medi-Cal and a non-billable code should be used. Examples of such reports would include but are not limited to:

- Social Security Insurance Evaluation Forms
- Jury Duty Excuses
- Letters requested by School Programs in order to determine eligibility
- CPS Report Forms

In general terms, if the service being provided is to aid another agency in determining client eligibility, it is not billable to Medi-Cal.

Service Location

Service location codes

The following provisions apply to service locations:

- There are no restrictions as to place, day, or time of day of service delivery (except for the residential services). Services may take place over the phone and/or on weekends
- The service locations on the CDI and the ID notes are the same, as follows:

    1) Clinic (DMH Site)
    2) Field/OOC/Jail (if no other codes apply)
        i. OOC stats for out-of-clinic
    3) Phone
    3) Non-Face-To-Face (preempts all other codes)
    4) Home
    5) Satellite (see Clinic Supervisor for definition)
    6) School
    7) Crisis in the field

- Use the following table to determine which codes to use:

If your service was...	**Then...**
Not performed face-to-face with a client or a collateral person,	Code your location first and the client's second as 3: • Example, 1-3 • All services delivered by phone are coded X-3
Performed face-to-face with a client or a collateral person,	Choose from among codes: • 1,4,5,6 and 2 • Using code 2 only as a last resort, if no other codes apply
Performed as a crisis in the field,	It is preferable to code as: • 4,5,6 or 2, rather than 7 • If it is reasonable to do so
If you think one of your service sites might be a satellite,	There are complex regulatory definitions, and your Clinic Supervisor should be consulted

Staffing or Team Meetings

Charting with multiple staff

It is acceptable to have one chart note, mentioning all participants, their disciplines, and why they were present, with a Plan Development billing equal to the time actually spent on that client multiplied by the number of people who actually participated in that discussion. The following scenarios are all acceptable billing:

- If a client were discussed for 6 minutes by 5 staff, it could be a single 30-minute billing by the person writing the chart note. The staff member present could divide up the clients discussed to do the chart notes (and therefore the billings.)
- An alternative procedure would be for each of the 5 staff to separately bill the 6 minutes, and to each write his/her own chart note
  - If the meeting includes only the Team Leader, and clinician (and /or the client), a single note is acceptable, with billing on one CDI as staff and co-staff.
- A third acceptable method is for one person to write a single note, mentioning the names of all actual participants, and each participant put that time 6 minutes, 9 minutes, etc. on his/her CDI without waiting a note

Subpayee Services

Not billable

Doing subpayee functions is not billable (but of course helping the client work on budgeting can be billed as rehab/ADL).

Time of Charting

Determining charting time

Use the following chart to determine how to bill charting time:

If...	Then...
You can do the charting before you turn in the CDI for the service itself,	Include the charting time in that service, even though you charted on a different day. Notes should be written no later than the next day and filed in the chart no later than 72 hours after the service.
You chart after you turn in the CDI with the billing for the service time itself,	Bill the charting time separately as Plan Development. Make clear on the note, however, • The minutes billed for the service itself (and the date of the service) • The minutes billed for the charting as Plan Development (and the date of the charting) • For example, head the note itself: – "7/23/06 0:06 MHS-Pl. Dev." and in the note, "This note is for 0:54 billed for Ind. ther. 7/22/06
More than one service occurs in one continuous session (collateral and individual, for instance),	There should be two separate ID notes and two separate billings each of its own proper amount of charting and plan development time added, if any.

Travel

How to bill travel time

The following considerations apply to billing for travel time:

- Travel time is not billed alone but always as part of a defined client service
- The time billed for a service should be consistent with the content of the ID note
- Travel time need not be separately identified in all cases, but if travel is a large enough proportion of the total time that the actual service described in the ID note does not seem appropriate to the time billed, then the ID note should include a statement such as:
  - “40 min. travel” or “33 min. travel”
- Reporting a location other that the clinic does not imply that travel took place. Travel not connected with a charted service of some sort is not billable

Treatment of Substance Problems

General

Substance diagnoses are acceptable as secondary diagnoses, but treatment services aimed primarily or substantially at the treatment of substance problems are not billable as mental health services.

Uniformity

Time entered on CDI	The time entered for a session on the ID note MUST be the same time that is billed for that session on the CDI.

Use Actual Time

What time should be billed

The time billed is the actual time used for billable services:

- 27 minutes (0.27), 33 minutes (0.33), etc.
- Do not use a standard session time (like 50 minutes) or a standard time for charting (like 10 minutes), but report the actual time used for that session for that client
- It is fraudulent to “pad” billing, by for example, adding 15 minutes for charting when you only spend 7 minutes charting

Forms in Other Languages

Purpose

In order to promote client participation in treatment and client understanding of the care process, certain chart forms may be issued in languages other than English.

Procedures

The following chart details the procedures for using forms in other languages:

Step	Action
1	Only translated forms issued by Quality Management will be placed in the chart.
2	When a translated form is placed in the chart, the corresponding English version will always be filed with it.
3	In the case of those forms requiring only signatures the: • English and translated versions may be copied back-to-back • Translated version would be signed • One not used would have a diagonal line drawn through it
4	In the case of those forms which have important content filled in, such as the Coordination Plan and Service Plan, the: • Clinician will fill in the non-English version in the other language • Signatures will go on the non-English version • Clinician will fill out a corresponding English version which will be filed in the chart with the non-English version

Order of Forms in an Open Chart

Form included All forms that could possibly be used in an open MHS chart are listed below. To use this list as a "procedure tool" make a copy and highlight ONLY those forms that are used in your clinic charts.

Section Number	Section Name	Form Names
1	Plans-Orders- MEDS	• Out-of-County Authorization • Client Recovery Plan • Care Necessity Form • Diagnosis Form • Outpatient TX Authorization Request (Approved)
TAB		
1		• ALERT SHEET for Allergies (if necessary) • Outpatient Medication Record • AIMS (Abnormal Involuntary Movement Scale) • Medications Consent • Physical Assessment
2	ID Notes	• Interdisciplinary (ID) Notes • Medication visit Interdisciplinary Note • Services Team Actions (File all ID Notes Chronologically) • Universal Referral Form • "This Chart Has Been Thinned" (a reminder)
TAB		
	Evaluation-Admission * "Do Not "thin" this section"	• Adult Clinical Assessment • Client Resource Evaluation • Adult Psychiatric Evaluation • Child/Adol Psychiatric Evaluation • Child/Adol Clinical Assessment • Client Recovery Evaluation (Annual) • Health Homes Assessment • AB 2726 Assessment/Assessment Plan • AB 2726 Clinical Assess Counseling • AB 2726 Clinical Assess Assaultive Behavior Addm • AB 2726 Clinical Assess Residential • AB 2726 Clinical Assess Mental Status Addm • AB 2726 Clinical Assess Firesetting Addm
3	Miscellaneous	• All School records-Adolescents • Group Home Agreement • Social Security Letters of Ruling • Determination, Sub-payee Orders • Change in Payment form

Form included, (Continued)

4	Consents/MISC	• Consent for Outpatient Treatment • Medical Care Authorization for Minor • Consent to Sound or Video Record • Behavioral Health Tele-Service Consent • Release and Hold Harmless Agreement • Children's Interagency Auth to Exch (PHI) • Notice of Privacy Practices Acknowledgement • Advanced Directives Notice • Delegation of TX Consent • Advance Beneficiary Notice (ABN) • Placement Application
5	Correspondence	• Index for Confidential Info Released (Attach copies of information released) (Attach copies of claims, form, etc.) • Authorization to Release Confidential (PHI) • Legal Papers: – Notice of Actions (NOA's) – Conservatorship, Court Orders, Guardianship – Treatment Attendance letters to patient from clinic – Subpoenas-Court Orders for records
6	Divided by Tabs	• (On TOP of tab section) • Registration Form • Client Episode Summary Form • Discharge Summary (when TX complete)
		TAB
	Identification	• Face Sheet SIMON report 140 • Initial Contact Form • Client Payment Agreement • AB 2726 Liability (Adolescent)
		TAB
	Physical	• Physical Exam (if available)
		TAB
	Psych-Testing	• Psych Testing report (if available) • General Report • Psychological Testing Referral • After Care or Discharge Sum (from Inpatient)
		TAB
	Clinical Lab	• Laboratory Reports (if available)
		TAB
	X-Ray/EKG	• X-Ray & EKG reports (if available)

Form included, (Continued)

Section Number	Section Name	Form Names
		TAB
	Consults – Old Episodes	• All prior episodes received from DBH or copies from outside facilities may be kept here. • Or, all pervious charting may be dept in a locked file in the clinic (enter "reminder" form in place of charting) – "RETURN OLD CHART WITH THIS EPISODE" • See Procedure 13 in this manual for sample forms and reminders

Changes to permanent chart forms

All changes to permanent chart forms or their placement in the chart shall be presented for approval to Quality Management. Clinic forms used only as "worksheets" in the open chart do not need approval.

Useful Links

ADP Bulletins and Letters Website
http://www.adp.cahwnet.gov/ADPLTRS/bulletin_letter.shtml

DBH FORMS
http://countyline.sbcounty.gov/dbh/SPM/Manual_Docs/appendices/APP03.pdf

DMH Letters and Notices Website
http://www.dmh.ca.gov/DMHDocs/default.asp?view=letters

Risk Management Website
http://countyline/riskmanagement/

Information Notices

09-01	01/27/09	Outpatient Chart Manual (OCM) Changes
08-06	11/05/08	Provider Resource Manual Update (related to TB P&P)
08-05	*Pending*	Audit check of CDI
08-04	11/24/08	Deficit Reduction Act
08-03	09/19/08	Issuance of NOA's
08-02	08/28/08	Signing of Client Plans
08-01	*Pending*	Reason for Discharge
07-05	12/10/07	Incentive Cards Procedure and Controls
07-04	11/21/07	Citizenship/Identity Status as a Condition of Medi-Cal Eligibility
07-03	09/13/07	Inappropriate Use of 5150
07-02	08/13/07	National Voter Registration Act of 1993
07-01	01/24/07	HIPAA National Provider Identifier