7.1.17 DOCUMENTATION REQUIREMENTS FOR ALL SPECIALTY MENTAL HEALTH SERVICES (SMHS), DRUG MEDI-CAL (DMC), AND DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM (DMC-ODS) SERVICES

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Policy Owner:	Department of Health Services, Behavioral Health Division (DHS-BHD), Utilization Review Manager, Quality Assessment & Performance Improvement (QAPI)
Director Signature:	**Signature on File**

I. Policy Statement

A. PURPOSE

This policy and procedure outlines the guidelines and requirements that streamline clinical documentation requirements for all Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS) services.

B. BACKGROUND

As part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, the Department of Health Care Services (DHCS), aims to reform behavioral health documentation requirements to improve member experience; effectively document treatment goals and outcomes; promote efficiency to focus on delivering person-centered care; promote safe, appropriate, and effective member care; address equity and disparities; and ensure quality and program integrity.

To achieve this aim, DHCS is streamlining and standardizing clinical documentation requirements across Medi-Cal SMHS, DMC, and DMC-ODS

services. These updated documentation requirements better align with Centers for Medicare and Medicaid Services' (CMS), national coding standards and physical health care documentation practices.

BHIN 23-068 superseded state regulations, as noted in Enclosure 2. BHIN 23-068 identifies care planning requirements that remain in effect in Enclosure 1a, and other data and documentation requirements that remain in effect in Enclosure 1b.

II. Scope

This policy applies to all DHS-BHD “Covered Persons” including employees (full-time, part-time, extra-help), unpaid interns, paid interns, temporary agency workers, registered volunteers, and all individual providers contractually designated as covered persons. Covered Persons do not include Community Based Organization (CBO) staff.

III. Definitions

A. Drug Medi-Cal (DMC): DMC is a treatment funding source for eligible Medi-Cal members. In order for DMC to pay for covered services, eligible Medi-Cal members must receive Substance Use Disorder (SUD) services at a DMC certified program. SUD services funded by DMC are listed in Title 22, California Code of Regulations (CCR), Section 51341.1. (d) (1-6). Title 9 and Title 22, CCR govern DMC treatment.

B. Drug Medi-Cal Organized Delivery System (DMC-ODS): The DMC-ODS provides a continuum of care modeled after the American Society of Addiction Medicine Criteria for SUD treatment services, enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance abuse treatment, and coordinates with other systems of care. This approach provides the member with access to the care and system interaction needed in order to achieve sustainable recovery. DHCS initially received approval in August 2015 from the Centers for Medicare & Medicaid Services (CMS), to implement the DMC-ODS through the State's prior Section 1115 demonstration. DHCS received approval from CMS on December 29, 2021, to reauthorize the DMC-ODS in the CalAIM Section 1915(b) waiver through December 31, 2026, alongside the State's other Medi-Cal Delivery Systems: Medi-Cal Managed Care, Medi-Cal Dental Managed Care, and SMHS.

C. Fee-For-Service (FFS) Medi-Cal Delivery System: Under FFS, the state pays enrolled Medi-Cal providers directly for covered services provided to Medi-Cal members. FFS providers render services and then submit claims for payment

that are adjudicated, processed, and paid (or denied), by the Medi-Cal program's fiscal intermediary.

D. Managed Care Plan (MCP): MCPs are responsible for the Medi-Cal physical healthcare benefit. They are also responsible for a portion of the mental health benefit and must provide specified services to adults diagnosed with a mental health disorder, as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM), that results in mild to moderate distress or impairment of mental, emotional, or behavioral functioning. MCPs must also provide medically necessary Non-Specialty Mental Health Services (NSMHS), to children under the age of 21. MCPs refer to and coordinate with County Mental Health Plans (MHPs) for the delivery of SMHS.

E. Non-Specialty Mental Health Services (NSMHS): NSMHS are delivered via MCP and FFS delivery systems and are provided to recipients 21 years and over with mild-to-moderate distress or mild-to-moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders. NSMHS may be provided to recipients under age 21, to the extent otherwise eligible for services, through Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), regardless of the level of distress or impairment, or the presence of a diagnosis —and recipients of any age with potential mental health disorders not yet diagnosed.

F. Specialty Mental Health Services (SMHS): SMHS include, but are not limited to: Assessment, plan development, rehabilitation services, therapy services, collateral services, medication support services, targeted case management, crisis intervention, Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), and Therapeutic Behavioral Services (TBS). SMHS are provided to Medi-Cal members through County MHPs. All the MHPs are part of county mental health or behavioral health departments and the MHP can provide services through its own employees or through contract providers.

IV. Policy

A. Applicability: The documentation standards identified in this policy apply to SMHS, DMC, and DMC-ODS services except for the following:

1. Narcotic Treatment Programs

2. Psychiatric Inpatient services provided in hospitals, psychiatric health facilities, or psychiatric residential treatment facilities

3. Inpatient services provided in chemical dependency recovery hospitals

B. Effective January 1, 2024, the chart documentation requirements for all SMHS, DMC, and DMC-ODS services are as established in the procedure below.

Deviations from compliance with documentation standards outlined below will require a corrective action plan. Recoupment shall be focused on fraud, waste, and abuse, as defined in the Code of Federal Regulations, Title 42, § 455.2 and W&I Code, section 14107.11, subdivision (d). Definitions for "fraud," "waste," and "abuse", can also be found in the Medicare Managed Care Manual.

C. DHCS removed member plan requirements from SMHS and treatment plan requirements from DMC and DMC-ODS, with the exception of continued requirements specifically noted in Enclosure 1a. DHCS also added new behavioral health documentation requirements, including requirements for problem lists, progress notes, and SUD assessments.

D. Services shall be provided in the least restrictive setting and shall be consistent with the goals of recovery and resiliency, learning and development, and enhanced self-sufficiency.

V. Procedures

A. Standardized Assessment Requirements

1. Timely Assessments — SMHS, DMC, and DMC-ODS:

a. To ensure that members receive the right service, at the right time, and in the right place, providers shall use their clinical expertise to complete initial assessments and subsequent assessments as expeditiously as possible, in accordance with each member's clinical needs and generally accepted standards of practice.

b. Assessments shall be updated as clinically appropriate, such as when the member's condition changes.

c. As part of a Medi-Cal behavioral health delivery system's Quality Assessment and Performance Improvement (QAPI) Program (SMHS and DMC-ODS), or programmatic and utilization review of providers (DMC), Medi-Cal behavioral health delivery systems shall monitor timely completion of assessments to ensure appropriate access to, and utilization of, services. Medi-Cal behavioral health delivery systems shall not enforce standards for timely initial assessments, or subsequent assessments, in a manner that fails to permit adequate time to complete assessments when such time is necessary due to a member's individual clinical needs.

d. Clinically appropriate and medically necessary services are covered and reimbursable when provided prior to the determination of a diagnosis, during the assessment, or prior to determination of whether SMHS, DMC, or DMC-ODS access criteria are met, even if the assessment ultimately

indicates the member does not meet the access criteria for the delivery system in which they initially sought care.

2. Crisis Assessments — SMHS, DMC, and DMC-ODS:

    a. Crisis assessments completed during the provision of SMHS crisis intervention or crisis stabilization, or a SMHS, DMC, or DMC-ODS mobile crisis services encounter, need not meet the comprehensive assessment requirements outlined in this policy. However, crisis assessments are not a replacement for a comprehensive assessment. When a member who has received a crisis assessment subsequently receives other SMHS, DMC, or DMC-ODS services, an assessment shall be completed in accordance with the requirements in this policy.

3. Assessments — SMHS:

    a. The MHP requires providers to use the uniform assessment domains as identified below. Assessment information should be comprehensive, consolidated, and can be produced and shared as appropriate to support coordinated care, in accordance with applicable state and federal privacy laws.

    b. For members under the age of 21, the Child and Adolescent Needs and Strengths (CANS) assessment tool continues to be required and may be utilized to help inform the assessment domain requirements. An initial CANS should be completed, or an existing CANS updated, by a CANS-certified provider.

    c. The time-period for providers to complete an initial assessment and subsequent assessments for SMHS are subject to clinical discretion; however, providers shall complete assessments within a reasonable time and in accordance with generally accepted standards of practice.

    d. The assessment shall include a typed, or legibly printed name, signature, title (or credentials) of the service provider, and the date of signature.

    e. The assessment shall include the licensed provider's recommendations for medically necessary services and additional provider referrals, as clinically appropriate. The problem list and progress note requirements identified below shall support the medical necessity of each service provided.

    f. The diagnosis, Mental Status Exam (MSE), medication history, and assessment of relevant conditions and psychosocial factors affecting the member's physical and mental health must be completed by a provider—operating in their scope of practice under California State law—who is

licensed, registered, waivered, and/or under the direction of a licensed mental health professional, as defined in the State Plan.

g. Both licensed and non-licensed providers, including those not qualified to diagnose a mental health condition, may contribute to the assessment, consistent with their scopes of practice.

4. Assessments — DMC and DMC-ODS:

a. Providers are required to use the American Society of Addiction Medicine (ASAM) Criteria assessment for DMC and DMC-ODS members.

b. The assessment shall include a typed or legibly printed name, signature, title(or credentials) of the service provider, and the date of signature.

c. The assessment shall include the provider's determination of medical necessity and recommendation for services. The problem list and progress note requirements, identified below, shall support the medical necessity of each service provided.

d. Both licensed and non-licensed providers, including those not qualified to diagnose a SUD, may contribute to the assessment consistent with their scope of practice. If the assessment is completed by a registered or certified counselor, then a Licensed Practitioner of the Healing Arts (LPHA) shall review that assessment with the counselor, and the LPHA shall make the initial diagnosis. The consultation between the LPHA and the registered or certified counselor can be conducted in person, by video conferencing, or by telephone. Covered and clinically appropriate DMC and DMC-ODS services (except for residential treatment services) are Medi-Cal reimbursable for up to **30 days** following the first visit with a LPHA or registered/certified counselor, whether or not a diagnosis for Substance-Related and Addictive Disorders from the current Diagnostic and Statistical Manual (DSM) is established, or up to **60 days** if the member is under age 21, or if a provider documents that the member is experiencing homelessness and therefore requires additional time to complete the assessment.

e. Licensed or certified SUD recovery or treatment programs are required to conduct evidence-based assessments of members' needs for Medications for Addiction Treatment (MAT). MAT assessments, as described in BHIN 23-054 or subsequent guidance, need not meet the comprehensive ASAM assessment requirements.

f. DMC and DMC-ODS providers shall use ASAM Criteria Assessment Interview Guide, or ASAM CONTINUUM software, or a validated tool approved by DHCS effective January 1, 2025.

5. Assessment Domain Requirements — SMHS:

    a. To the extent the information is available, the SMHS comprehensive assessment should include all of the following components, listed within each of the seven required domains. Providers shall document the domain information in the SMHS assessment in the member's medical record. Providers shall complete the assessment within a reasonable time, and in accordance with generally accepted standards of practice.

        i. Domain 1:

            (1) Presenting Problem(s)

            (2) Current Mental Status

            (3) History of Presenting Problem(s)

            (4) Member-Identified Impairment(s)

        ii. Domain 2:

            (1) Trauma

        iii. Domain 3:

            (1) Behavioral Health History

            (2) Co-occurring Substance Use

        iv. Domain 4:

            (1) Medical History

            (2) Current Medications

            (3) Co-occurring Conditions (other than substance use)

        v. Domain 5:

            (1) Social and Life Circumstances

            (2) Culture/Religion/Spirituality

        vi. Domain 6:

            (1) Strengths, Risk Behaviors, and Protective Factors

vii. Domain 7:

(1) Clinical Summary and Recommendations

(2) Diagnostic Impression

(3) Medical Necessity Determination/Level of Care/Access Criteria

B. Problem List — SMHS, DMC, and DMC-ODS:

1. The provider(s) responsible for the member's care shall create and maintain a problem list.

   a. The problem list may include symptoms, conditions, diagnoses, social drivers, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters. The problem list shall include, but is not limited to, the following:

      i. Diagnosis/es identified by a provider acting within their scope of practice, if any.

         (1) Diagnosis-specific specifiers from the current Diagnostic and Statistical Manual of Mental Disorders (DSM) shall be included with the diagnosis, when applicable.

      ii. Current International Classification of Disease (ICD),Clinical Modifications (CM) codes.

      iii. Problems identified by a provider acting within their scope of practice, if any.

      iv. Problems identified by the member, and/or significant support person, if any.

         (1) The name and title (or credentials), of the provider who identified, added, or resolved the program, and the date the problem was identified, added, or resolved.

2. Problems identified during a service encounter may be addressed by the service provider (within their scope of practice) during that service encounter and subsequently added to the problem list.

3. The problem list shall be updated on an ongoing basis to reflect the current presentation of the member. Providers within their scopes of practice should add to, amend, or resolve problems from the problem list when there is a relevant change to a member's condition.

4. The problem list shall be reviewed and updated as clinically indicated (e.g., following crisis intervention or hospitalization) and coordinated with outpatient mental health Network Providers.

5. DHCS does not require the problem list to be updated within a specific timeframe or have a requirement about how frequently the problem list should be updated after a problem has initially been added. However, providers shall update the problem list within a reasonable amount of time and in accordance with generally accepted standards of practice.

C. Progress Notes —SMHS, DMC, and DMC-ODS:

1. Providers shall create progress notes for the provision of all SMHS, DMC, and DMC-ODS services. Each progress note shall provide sufficient detail to support the service code selected for the service type, as indicated by the service code description.

2. Should more than one provider render a service, either to a single member or to a group, at least one progress note per member must be completed. The note must be signed by at least one provider. The progress note should clearly document the specific involvement and duration of the direct member care for each provider of the service.

3. Progress notes for all non-group services shall include:

   a. The type of service rendered.

   b. A brief description of how the service addressed the member's behavioral health needs (e.g., symptoms, conditions, diagnosis, and/or risk factors).

   c. The date that the service was provided to the member.

   d. Duration of the direct member care for the service, including travel and documentation time (in separate fields from direct service location).

   e. Location/place of service.

   f. A typed or legibly printed name, signature, title (or credentials) of the service provider, and the date of signature.

   g. Next steps including, but not limited to, the planned action steps by the provider or by the member, collaboration with the member, collaboration with other provider(s), and any update to the problem list as appropriate.

4. Progress notes for group services:

    a. When a group service is rendered, a list of participants is required to be documented and maintained by the provider.

    b. Every participant must have a progress note in their clinical record that documents the group service encounter and their attendance in the group shall include:

        i. Type of service rendered.

        ii. Date that the service was provided to the member.

        iii. Duration of the direct member care for the services.

        iv. Location/place of service.

        v. A typed or legibly printed name, signature, title (or credentials) of the service provider, and the date of signature.

        vi. A brief description of the member's response to the service.

    c. The contents of the progress note should support the service(s) selected and support effective clinical care and coordination among providers. Notes shall include the minimum elements outlined above, but the nature and extent of the information included may vary based on the service type and the member's clinical needs. If information is located elsewhere in the clinical record, it does not need to be duplicated in the progress notes.

5. Providers shall complete progress notes within **three business days** of providing a service, with the exception of notes for crisis services, which shall be completed within **one calendar day**. The day of the service is considered day zero.

6. Providers shall complete at minimum, a daily progress note for services that are billed on a daily basis, such as Crisis Residential Treatment, Adult Residential Treatment, DMC-ODS Residential Treatment, and day treatment services (including Therapeutic Foster Care, Day Treatment Intensive, and Day Rehabilitation). If a bundled service is delivered on the same day as a second service that is not included in the bundled rate, there must also be a progress note to support the unbundled service.

D. Care Planning Requirements — SMHS, DMC, and DMC-ODS:

1. DHCS no longer requires prospectively completed, standalone member plans for Medi-Cal SMHS, or prospectively completed, standalone treatment plans

for DMC and DMC-ODS services. Care planning is an ongoing, interactive component of service delivery, rather than a one-time event.

2. Please see Enclosure 1a for the full list of treatment plan requirements that are outside the scope of SMHS, DMC, or DMC-ODS specific requirements. Where there is a conflict between Enclosure 1a and the policy, Enclosure 1a requirements shall apply. Several of these care plan requirements remain in effect due to applicable federal regulations or guidance. For SMHS, DMC, and DMC-ODS services, programs, or facilities for which the plan requirements remain in effect:

    a. Providers must adhere to all the relevant care planning requirements in state or federal law.

3. Providers should document the required elements of the care plan within the member record. For example, required care plan elements may be notated within the assessment record, problem list, or progress notes, or the provider may use a dedicated care plan template within an Electronic Health Record.

4. To support delivery of coordinated care, the provider should be able to produce and communicate the content of the care plan to other providers, the member, and Medi-Cal behavioral health delivery systems, in accordance with applicable state and federal privacy laws.

E. Targeted Case Management (TCM) – SMHS, DMC-ODS:

1. TCM services within SMHS may additionally require the development, monitoring, and periodic revision of a specific care plan, based on the information collected through the assessment. The TCM care plan:

    a. Specifies the goals, treatment, service activities, and assistance, to address the negotiated objectives of the plan and the medical, social, educational, and other services needed by the member.

    b. Includes activities such as ensuring the active participation of the member and working with the member (or the member’s authorized health care decision maker), and others, to develop those goals.

        i. Identifies a course of action to respond to the assessed needs of the member; and

        ii. Includes the development of a transition plan when a member has achieved the goals of the care plan.

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

(1) Monitoring and follow-up activities should be conducted as clinically necessary, and at least once annually.

F. Peer Support Services —SMHS, DMC, DMC-ODS:

1. Peer support services must be based on an approved plan of care. The plan of care shall be documented within the progress notes in the member's clinical record, and approved by any treating provider who can render reimbursable Medi-Cal services.

2. Additional Treatment and Care Plan Requirements

   a. Requirements for treatment and care planning for additional service types are found in Attachment 1.

G. Documentation of Telehealth Services and Consent – SMHS, DMC, DMC-ODS:

1. Refer to policy 7.1.8 Telehealth Services

VI. Forms

MHS 105 Procedure Codes for Member Related Activities

VII. Attachments

Enclosure 1a: Care Planning Requirements that Remain in Effect

Enclosure 1b: Other Data and Documentation Requirements that Remain in Effect

Enclosure 2: Superseded Regulations