SECTION VIII – DOCUMENTATION STANDARDS, TREATMENT STANDARDS AND MEDICAL NECESSITY CRITERIA

DOCUMENTATION STANDARDS

Each network provider must open and maintain his/her own clinical mental health record in order to document complete, accurate and current documentation of all services provided, including assessment activities. The record must be secured and kept confidential in a secured and locked file. Additional information and regulations on Clinical Records Maintenance can be located in Department of Mental Health, Quality Assurance (QA), Policy 401.01 dated 12/27/21.

Network providers are not required to use the LMHP forms for documenting clinical services; however, LMHP forms can be used as long as the documentation complies with Medi-Cal requirements and meets medical necessity criteria. Minimal documentation requirements are reflected on the LMHP forms.

OUTPATIENT MEDICAL NECESSITY CRITERIA

Previously, every service claimed, other than those for assessment purposes, must meet the test of medical necessity; i.e., the service must be directed towards reducing or ameliorating the effect of symptoms/behaviors of an included diagnosis causing functional impairments or, minimally, preventing an increase of those symptoms/behaviors or functional impairments.

Effective January 1, 2022, updated criteria to access Medi-Cal Specialty Mental Health Services (SMHS) for outpatient services are a part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative. Refer to QA Bulletin 21-07 (Attachment I) & QA Bulletin 21-08 (Attachment II).

Based on these criteria changes in California Advancing and Innovating Medi-Cal (CalAIM) initiative, medical necessity will no longer refer to the previously “medical necessity” criteria, which created barriers and prevented beneficiaries from accessing care, and now medical necessity applies to the service (i.e, whether the service is medically necessary), while criteria to access SMHS applies to the person or whether the person is eligible to receive SMHS.)

You will find below a brief overview of changes to criteria, please refer to QA Bulletin 21-08 (attached) for details on applying DSM and ICD for a diagnosed mental health disorder. While a mental health diagnosis is not a prerequisite to access SMHS, this does not eliminate the requirement that all Medi-Cal claims include a CMS valid ICD-10 diagnosis code. Please refer to codes for “Other specified” and “Unspecified disorders”, or “Factors influencing health status and contact with health services: (Z codes).

Beneficiaries Under Age 21

The criteria to access SMHS (previously known as medical necessity criteria) have been updated for both adults and beneficiaries under age 21 (except for psychiatric inpatient hospital and psychiatric health facility services) to ensure access to appropriate care and to standardize access to SMHS delivery system statewide. As noted earlier, medical necessity now applies to the service (i.e., whether the service is medically necessary), while criteria to access SMHS applies to the person or whether the person is eligible to receive SMHS.)

The criteria to access SMHS for Beneficiaries Under 21 Years include these changes to criteria:

- Beneficiaries under age 21 do not need to have significant impairments to access SMHS
- There is no longer a list of "included" diagnoses
- A mental health disorder or suspected mental health disorder not yet diagnosed meets criteria for SMHS
- A mental health diagnosis is no longer a prerequisite for receiving or delivering SMHS
- Those who have a condition placing them at high risk due to trauma can access SMHS

Beneficiaries 21 Years and Older

The criteria to access SMHS and eligibility to receive services under the Mental Health Plan (MHP) for LACDMH include Criteria for Beneficiaries 21 Years and Older to Access SMHS include these changes to criteria:

- There is no longer a list of "included" diagnoses
- A mental health disorder or suspected mental health disorder not yet diagnosed meets criteria for SMHS
- A mental health diagnosis is no longer a prerequisite for receiving or delivering SMHS
- SMHS are reimbursable for beneficiaries with medical diagnoses if they also have mental health conditions and meet criteria for access to SMHS
- Beneficiaries 21+ must still have significant impairment in life functioning due to a mental health disorder or suspected mental health disorder and/or probability of significant deterioration in life functioning in order to meet criteria for SMHS

Each time a service is claimed, the provider who delivered the service and submitted the forms should refer to information contained in this section. Network providers must adhere to the clinical records content and documentation standards of the LMHP. The minimum content includes both administrative and clinical documentation.

> **Note:** Requirements for Psychological Testing and Over-threshold services to obtain authorization from the Local Mental Health Plan and to use the LMHP forms for documenting clinical services are no longer valid as of 09/01/2020.

If a network provider uses any forms other than the forms in this Provider Manual, each page must include the Medi-Cal beneficiary's name, the Department of Mental Health (DMH) Client ID Number, the name of the individual or group network provider and a confidentiality/disclosure statement similar to the statement on the LMHP forms.

The State of California Department of Health Care Services (DHCS) Information Notice No. 20-043, 2020 International Classification of Diseases, Tenth Revision (ICD-10) was published on July 8, 2020. The included Code Sets are effective beginning October 1, 2019 and will remain in effect until new guidance is issued.

The DHCS Information Notices can be found in the DHCS Homepage at: www.dhcs.ca.gov Under '*Providers and Partners'* > '*Letters, Notices, and Bulletins'* then, > 'MHSUDS/Behavioral Health Bulletins, Information Notices, and Letters' and then, under '2020 MHSUDS/BH Information Notices'.

Annual updates will be published through the Quality Assurance Bulletin. Network Provider should keep abreast of Quality Assurance Bulletins on updated changes to allowable diagnoses.

DSM-IV criteria should continue to be used for Pervasive Developmental Disorders (Autistic Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, Rett's Disorder, and Pervasive

Developmental Disorder Not Otherwise Specified) because DSM-5 only has a single diagnosis of Autism Spectrum Disorder and the list of included diagnoses does not account for this. ICD-10-CM codes can be found for each of the DSM-IV Pervasive Developmental Disorders. Refer to DMH, Quality Assurance Bulletin, No.20-03, dated 08/13/20.

The diagnosis in the clinical record must be consistent with the most recent and up-to-date clinical information documented in the assessment.

DHCS and LACDMH will not require standardized forms for the Assessment, Problem List, Care Plan or Progress Note requirements identified below. For contracted providers including Individual and Group Providers DMH forms are not required but may be utilized if desired. Contracted providers are responsible for ensuring their documentation meets the below requirements.

ASSESSMENT

What Has to be Documented:

The initial and subsequent Assessments should be completed within a reasonable period of time and in accordance with generally accepted standards of practice. There is no longer a requirement to complete the Assessment within 60 days from the start of the Assessment or before any treatment services; however, efforts should be made to complete the Assessment as quickly as possible in-order-to move the client into treatment, if indicated.

Assessments must contain the required seven (7) uniform Assessment domains as identified below, but there is no requirement for the domains to be laid out in this manner. For clients under the age of 21, the Child and Adolescent Needs and Strengths (CANS) Assessment tool may be utilized to help inform the Assessment domain requirements but is not sufficient as the Assessment in-and-of itself.

Domain 1
Presenting Problem(S) • Current Mental Status • History of Presenting Problem(s) • Client Identified Impairment (s)

Domain 2
Trauma

Domain 3
Behavioral Health History (including Substance Use History) • Comorbidity (i.e., substance use & mental health

Domain 4
Medical History • Current Medications • Comorbidity (i.e., medical & mental health)

Domain 5
Social and Life Circumstances • Culture/Religion/Spirituality

Domain 6
Strengths, Risk Behaviors & Safety Factors

Domain 7
Clinical Summary & Recommendations • Diagnostic Impression • Medical Necessity Determination/ Level of Care/ Access Criteria

For children or certain other beneficiaries who are unable to provide a history, this information may be obtained from the parents/caregivers, etc.

Detailed, itemized data elements for each domain are no longer required. Domains are now described in a more general manner. The result is that greater flexibility is afforded the assessing clinician to focus on areas of relevance.

Medical necessity now applies to the service (i.e., whether the service is medically necessary), while criteria to access SMHS applies to the person (i.e., Whether the person is eligible to receive SMHS). For Contractors with an Electronic Health Record System (EHRS), the relevant form with all required data elements shall be used.

Who Can Document:

The diagnosis, Mental Status Exam (MSE, medication history and assessment of relevant conditions and psychosocial factors affecting physical and mental health must be completed by a practitioner operating within their scope of practice, who is licensed.

Providers may designate certain other qualified practitioners to contribute to the Assessment, including gathering mental health and medical history, substance exposure and use, and identifying strengths, risks and barriers to achieving goals.

Timeframe/Frequency of Documentation:

- Initial and subsequent Assessments should be completed within a reasonable period of time and in accordance with generally accepted standards of practice. There is no longer a requirement to complete the Assessment within 60 days from the start of the Assessment or before any treatment services; however, efforts should be made to complete the Assessment as quickly as possible in-order-to move the client into treatment, if indicated.
- Although it is not the standard course of action, under certain limited circumstances (e.g., the client is running out of medication) the Initial Medication Evaluation (IME) may serve as the Assessment if the MD/NP/DO is the most appropriate first contact for the client. Please note that in these instances the IME should focus on a broad evaluation of the client's needs similarly to the standard Assessment. A standard Assessment is not required to be completed in addition to the IME unless there is clinical justification to further assess the client.
- The frequency of the Assessment is up to clinical discretion. Triannual Assessments are no longer required. There is no longer a requirement to complete an Assessment Addendum when there is additional information gathered, whether a change or addition, after the completion of the Assessment. Instead, refer to the new requirements involving the Problem List to identify the current present issues and needs of the client. If it is determined that another Assessment is needed, existing information should be reviewed and incorporated to minimize redundancy in questioning.
- If a diagnosis requires updating post-Assessment, information supporting the new diagnosis may be documented in a progress note. An Assessment Addendum supporting

the change in diagnosis is no longer required. For DO providers, it is recommended that the progress note supporting the change in diagnosis is referenced in the comments field of the Diagnosis Form.

- If a provider is accepting a client referred or transferred from another provider, the accepting provider may choose to do an Assessment or use the Assessment from the referring provider based on clinical judgment. Similarly, if a client is coming back into treatment the provider may choose to do an Assessment based on clinical judgment, taking into account factors including the period of time elapsed since the client was last seen, the age of the client, and whether the client's current symptoms are consistent with the prior diagnosis. If it is determined that another Assessment is needed, existing information should be reviewed and incorporated to minimize redundancy in questioning.

The primary assessment forms at this time are:

- *Child/Adolescent Full Assessment form MH533 (*Attachment III*)* http://file.lacounty.gov/SDSInter/dmh/1058268_MH533ChildAdolesFullAssess7-1-19fillable.pdff;
- *Adult Full Assessment form MH532 (*Attachment IV*)* http://file.lacounty.gov/SDSInter/dmh/1058271_MH532AdultFullAssess7-1-19fillable.pdf;

Note: The Child/Adolescent Assessment Addendum and Re-Assessment and the Adult Assessment Addendum and Re-Assessment are no longer required. The Re-Assessment forms may continue to be used for returning clients when clinically appropriate. In an effort to streamline Assessment documentation, remove redundancies and make the forms more user-friendly, the Assessment forms will be modified in the future, including removing the Addendum and Re-Assessment forms.

The *Child/Adolescent Assessment Addendum* form 536A http://file.lacounty.gov/SDSInter/dmh/1058266_MH536AChildAdolescentAssessAddendum7-1-19fillable.pdf or
The *Adult Assessment Addendum* form 532A http://file.lacounty.gov/SDSInter/dmh/1058268_MH533ChildAdolesFullAssess7-1-19fillable.pdf
(Attachment V & VI) are to be used if additional writing space is needed for the initial assessment, for assessment updates, or to confirm information on the original assessment.

PROBLEM LIST

What Has to be Documented:

The Problem List must contain:

- Symptoms, conditions, diagnoses, and /or risk factors identified through the Assessment, diagnostic evaluation, crisis encounters or other types of service encounters:
  - Diagnoses identified by a practitioner acting within their scope of practice, if any.
  - Problems identified by a practitioner acting within their scope of practice, if any.
  - Problems or illnesses identified by the client and /or significant support person, if any.

- The name and title of the provider that identified, added or removed the problem and the date the problem was identified, added or removed.

A code set for the Problem List is not required, a standard-based coding system such as the CORE Problem List subset of SNOMED CT is highly recommended for future interoperability and coordination of care requirements. Licensing is required to use the CORE SNOMED CT codes:

- The CORE Problem List Subset of SNOMED CT (nih.gov)

DMH recognizes that the "Problem List" is not a strength-based term; however, since it is a widely recognized term -of – art, it will be retained in-order-to remain consistent with physical health care system language for care coordination and integration. This does not mean that providers should only focus on the client's problems. A client's strengths are identified in the Assessments, CANS, NET and progress notes and should continue to be capitalized upon throughout treatment.

Who Can document:

- Any practitioner on the treatment team can add problems to the Problem List as it is a reporting form.
- Providers should update the Problem List on an ongoing basis to reflect the current presentation of the client.

TREATMENT PLAN

As of July 1, 2022 the Client Treatment Plan will be obsolete. The formal Client Treatment Plan no longer requires any service or program other than services rendered within STRTPs.

Care planning with clients is a standard of practice which helps to organize and guide treatment. Care Plans assist in ensuring clients continue to move forward on a path to recovery. For specific services (i.e., Targeted Case Management (TCM), Intensive Care Coordination (ICC), Therapeutic Behavioral Services (TBS), and Intensive Home-Based Services (IHBS)), DHCS and the Centers for Medicare and Medicaid Services (CMS) continue to require the development and periodic revision of a Care Plan.

This Care Plan can be documented in the client progress notes within the Next Steps section. Please refer to the next section on Progress Notes for additional information on Care Plan requirements.

NETWORK PROVIDER PROGRESS NOTE

Service documentation should at a minimum include a recording for every service rendered on the *Progress Note form MH515* (Attachment VII)
http://file.lacounty.gov/SDSInter/dmh/084389_cms1_084389.pdf

Progress notes help ensure quality and continuity of care and are required to support claims. The content of the progress note should reflect client care, clinical decisions, interventions, progress, and referrals (when appropriate). The progress notes must describe how the services provided reduced the identified impairment(s), restored functioning, or prevented significant deterioration.

The progress note must include:

- Date and time of service;
- The date of the service was documented in the medical record by the person providing the service;
- The amount of time taken to provide services;
- Procedure code;
- Location of service;
- Timely documentation of relevant aspects of client care, including documentation of medical necessity;
- A description of changes in the medical necessity criteria when they occur;
- Documentation of beneficiary encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions;
- Interventions applied, beneficiary's response to the interventions;
- Documentation of referrals to community resources and other agencies, when appropriate;
- Documentation of follow-up care, or if appropriate, a discharge summary;
- For family therapy, clear documentation of family therapeutic interventions shall be clearly documented. The first names of the family members in attendance must be documented; however, only one claim for the family session is to be submitted, regardless of the number of family members present.
- The discharge summary (when applicable), if not recorded on a separate form; and
- The signature of the person providing the service (or electronic equivalent), the person's type of professional degree, licensure or job title and the relevant identification number; and
- Documentation for all unique services such as psychological testing, family and group therapy, medication support, etc. The type of service may be abbreviated, e.g., assessment-A, individual-I, group-G, psychological testing-PsyT, medication-Meds;
- Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS)
- ICD 10 code (the ICD 10 code is not required to be on the progress note but must appear in the clinical record, associated with each encounter and consistent with the description in the progress note)
- Next steps including, but not limited to, planned action steps by the practitioner or by the client, collaboration with the client, collaboration with other provider (s) and any update to the Problem List as appropriate.

Other key features to remember regarding Progress Notes:

- Notes must be legible;
- References to other clients should only be by first name or initials;
- White-out or other forms of error correction materials are not allowed;
- If a mistake is made, place a single line through the mistake, write "mistaken entry", initial, discipline and date;

- Never skip lines when writing the note;
- Cross out all unused lines at the bottom of the entry; and
- Use black ink. The use of felt tip pens is not acceptable.

When a group service is rendered, a list of participants is required to be documented and maintained by the practitioner. Should more than one practitioner render a group service, one progress note may be completed and signed by one practitioner. While one progress note with one practitioner signature is acceptable where multiple practitioners are involved, the progress note should clearly document the specific amount of time and involvement of each practitioner, including documentation time. Please note that this rule also applies to those situations in which multiple practitioners serve an individual client.

With the exception of services in an STRTP, the next steps within the Progress Note may serve as the Care Plan for services that continue to require a documented Care Plan. Practitioners should be careful to ensure that the next steps lay out the planned interventions to assist the client and that the client participates in identifying the next steps. The next steps should not simply be a statement of the next appointment date.

Progress Notes for treatment services are no longer required to link back to the Client Treatment Plan and Assessment (previously referred-to as the "Clinical Loop"). The focus of the note is on describing what was done to address the client's needs and the planned next steps in the treatment of the client. Practitioners should continue to document relevant information that is pertinent to the client's treatment for the purposes of care coordination and good clinical documentation.

Timeliness/Frequency of Progress Notes.

There must be documentation on the progress notes for every Specialty Mental Health Services, Medication Support or Crisis Intervention provided.

Providers shall complete the progress notes within 3 business days of providing a service, with the exception of notes for crisis services, which shall be completed within 24 hours (Refer to *DHCS BHIN No. 22-019).*

Requirements for Claiming for Service Function Based on Minutes of Time

For Individual and Group Providers, Mental Health Services and Medication Support are billed in minutes of time. The following requirements apply for claiming of services:

1. The exact number of minutes used by persons providing a reimbursable service shall be reported and billed. In no case shall more than 60 minutes of time be reported or claimed for any one person during a one-hour period. In no case shall the units of time reported or claimed for any one person exceed the hours worked.
2. When the person provides service to or on behalf of more than one beneficiary at the same time, the person's time must be prorated to each beneficiary. When more than one person provides a service to more than one beneficiary at the same time, the time utilized by all those providing the service shall be added together to yield the total claimable

services. The total time claimed shall not exceed the actual time utilized for claimable services.

3. For the Network Provider's Family therapy services, the documentation shall include family therapeutic interventions. The first name of the family members in attendance shall be documented in the medical record. Only one claim for the family session is to be submitted, regardless of the number of family members present.

MEDICATION SERVICES

Psychiatrists and nurse practitioners prescribing medications must document that the Medi-Cal beneficiary or the person responsible for the Medi-Cal beneficiary understands and agrees to the administration of the psychiatric medications that are being prescribed. This understanding is known as *Informed Consent*. Informed consent must be obtained and documented when a new or different type of medication is prescribed or at least annually and if a client resumes taking medications (Refer to *Section VII: Consents and Release of Information Forms*).

Elements to be documented on the *Informed Consent* shall include but not limited to:

- the reasons for taking such medications;
- reasonable alternative treatments available, if any;
- the type, range of frequency and amount, method (oral or injection), and duration of taking the medication;
- probable side effects, possible additional side effects which may occur to beneficiaries taking such medication beyond three (3) months; and,
- The written medication consent form must be signed by the beneficiary.
- the consent, once given, may be withdrawn at any time by the beneficiary.

A progress note should be used when medications are prescribed to document the service provided. (Refer to *Section IX: Procedure Codes, Diagnosis Codes and Rates*, for the appropriate use of Medication Support/Evaluation and Management Procedure Codes).

The progress notes must include:

- Name, dosage, and quantity of the medication;
- Frequency and route of administration.
- Presence or absence of side effects;
- Response to medication(s), both positive and negative; and
- The beneficiary's compliance with the medication regime.

When medications or dosages are changed, the reason for the change must be documented.

DISCHARGE SUMMARY

A progress note should be used to document the discharge summary and must be written within 30 days of discharge.

The progress note must include:

- Admission date;
- Presenting problem;
- Summary of the services delivered;
- Medications (if any);
- Referrals;

- Recommendations and follow-up plan if applicable; and
- Reason for termination and a discharge diagnosis

Outpatient Treatment Standards

In addition to the medical necessity criteria listed above, the LMHP requires the presence of a valid and complete treatment plan and the general standards listed below:

A. Network Provider

- Must be credentialed and contracted through the LMHP;
- Must render specialty mental health services to accomplish the treatment goals; and
- Must be accessible and engaged in a good working relationship with the LMHP.
- Network Providers who provide Psychiatric Inpatient Hospital Professional Services shall apply the medical necessity criteria found in CCR, Title 9, Chapter 11, Section 1820.205.
- Network Providers who provide Outpatient Specialty Mental Health Services shall apply the medical necessity criteria based on the CalAIMS initiative discussed above.
- Must maintain a complete clinical record in accordance with the structure and content specified by County DMH. All services provided to a beneficiary, for which Medi-Cal reimbursement is sought, must be documented in this record in a manner which complies with all applicable regulations and standards established by State Department of Health Care Services and County DMH.
- The Network Provider shall provide clinical records to County, and any Federal or State Department representatives having monitoring or reviewing authority, at reasonable times during normal business hours. Furthermore, the Network Provider shall provide access to and the right to monitor all work performed under the Network Agreement to evaluate the quality, ensure appropriateness and timeliness of services performed.

B. Treatment Services

- Must be generally acknowledged as the most effective and safe treatment modality available for achieving the treatment goals specific to the diagnosis and severity of symptomatology;
- Must be delivered with a level of intensity consistent with the diagnosis and severity of symptoms;
- Must have a reasonable expectation of effectiveness in a time frame consistent with acceptable standards of treatment specific to the diagnosis; and
- Must be consistent with the wishes of the Medi-Cal beneficiary.

C. Treatment Course

- Progress rate must be appropriate;
- Must have ongoing post-treatment and discharge planning;
- Complications must be appropriately managed;
- Medi-Cal beneficiary must have an appropriate level of satisfaction with the care.

CLINICAL RECORD CONTENT

Clinical Minimum Record Content	Attachment	Comments
Referral Information from LMHP	N/A	Referral Information from LMHP
Medication Informed Consent	Refer to Medication Services for elements of an Informed Consent	Must be signed and can be withdrawn at any time by beneficiary. Obtained annually.
Network Provider Child/Adolescent Assessment OR Network Provider Adult Assessment	Attachment III Attachment IV	An assessment must be completed for all new Medi-Cal beneficiaries within 60 days of admission. All required elements must be present
Network Provider Child/Adolescent Assessment Addendum OR Network Provider Adult Assessment Addendum	Attachment V Attachment VI	An assessment addendum may be used when any changes/updates are made to the assessment in the clinical record
Network Provider Progress Note	Attachment VII	Required for every service rendered.

You may refer to QA Clinical forms at: https://dmh.lacounty.gov/qa/qacf/