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

MICHELLE BAASS
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: April 22, 2022

Behavioral Health Information Notice No: 22-019
Supersedes MHSUDS Information Notice No.: 17-040

TO: California Alliance of Child and Family Services
California Association for Alcohol/Drug Educators
California Association of Alcohol & Drug Program Executives, Inc.
California Association of DUI Treatment Programs
California Association of Social Rehabilitation Agencies
California Consortium of Addiction Programs and Professionals
California Council of Community Behavioral Health Agencies
California Hospital Association
California Opioid Maintenance Providers
California State Association of Counties
Coalition of Alcohol and Drug Associations
County Behavioral Health Directors
County Behavioral Health Directors Association of California
County Drug & Alcohol Administrators

SUBJECT: Documentation requirements for all Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS) services

PURPOSE: To streamline clinical documentation requirements for all SMHS, DMC, and DMC-ODS services

REFERENCE: Welfare & Institutions Code (W&I), § 14184.402, subd. (h)(3)

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 the beneficiary experience; effectively document treatment goals and outcomes; promote efficiency to focus on delivering person-centered care; promote safe, appropriate and effective beneficiary 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 guidelines

do not apply to nonspecialty behavioral health services in Fee for Service and Medi-Cal managed care. These updated documentation requirements better align with Centers for Medicare and Medicaid Services' national coding standards and physical health care documentation practices.

Assembly Bill (AB) 133 (Committee on Budget, Chapter 143, Statutes of 2021) implements various components of the CalAIM initiative, including those components in W&I sections 14184.100, et seq. DHCS is authorized to develop and implement documentation standards through this Behavioral Health Information Notice (BHIN) until DHCS promulgates or amends regulations by July 1, 2024. (W&I, § 14184.402, subds. (h)(3) and (i)(1).)

Effective July 1, 2022, the chart documentation requirements for all SMHS, DMC, and DMC-ODS services are as established below. These criteria were developed based on significant feedback from stakeholders, including county behavioral health directors, consumer advocates, labor organizations representing county behavioral health workers, and mental health and substance use disorder treatment providers.

This BHIN supersedes state regulations as noted in Attachment 2, BHIN 21-046 in part (related to client plan and signature requirements), MHSUDS IN 17-040 in full, and BHINs or other guidance in existence as of the date of publishing this BHIN regarding documentation requirements for SMHS, DMC, and DMC-ODS services except as outlined in Attachment 1. To the extent that there is conflict between the MHP contract, DMC contract, or the DMC-ODS Intergovernmental Agreement terms and this BHIN, the policy contained within the BHIN supersedes the contract terms.

POLICY:

Overarching Policy

DHCS will monitor plans and counties for compliance with documentation standards outlined below, and deviations from the standards will require corrective action plans. Recoupment shall be focused on fraud, waste, and abuse.[1]

DHCS removed client plan requirements from SMHS and treatment plan requirements from DMC and DMC-ODS, with the exception of continued requirements specifically

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

noted in Attachment 1, and replaced them with these new behavioral health documentation requirements, including problem list and progress notes requirements.

The documentation standards identified in this policy focus on non-hospitalization services. Concurrent Review Standards for applicable services can be found in forthcoming guidance. DHCS will not require standardized forms for the assessment domains, problem list, or progress notes.

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.

(1) Standardized Assessment Requirements

A. SMHS
   a. MHPs shall require providers to use uniform assessment domains as identified below. For beneficiaries 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.
   b. The time period for providers to complete an initial assessment and subsequent assessments for SMHS is up to clinical discretion; however, providers shall complete assessments within a reasonable time and in accordance with generally accepted standards of practice.
   c. Services provided prior to determination of a diagnosis, during the assessment, or prior to determination of whether NSMHS or SMHS access criteria are met are covered and reimbursable, even if the assessment ultimately indicates the beneficiary does not meet criteria for SMHS.[2]
   d. The assessment shall include a typed or legibly printed name, signature of the service provider and date of signature.
   e. 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.
   f. The diagnosis, Mental Status Exam (MSE), medication history, and assessment of relevant conditions and psychosocial factors affecting the beneficiary's physical and mental health must be completed by a provider, operating in his/her scope of practice under California State law, who is

[2] For more detailed information on this policy refer to the No Wrong Door BHIN 22-011.

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

g. The Mental Health Plan (MHP) may designate certain other qualified providers to contribute to the assessment, including gathering the beneficiary's mental health and medical history, substance exposure and use, and identifying strengths, risks, and barriers to achieving goals. (Cal. Code Regs., tit. 9, § 1840.344; California State Plan, Sec. 3, Att. 3.1-A, Supp. 3, pp. 2m-p; California State Plan Section 3, Att.3.1-B, Supp. 2, pp. 15-17)

B. DMC and DMC-ODS

a. Counties shall require providers to use the American Society of Addiction Medicine (ASAM) Criteria assessment for DMC and DMC-ODS beneficiaries.
b. The assessment shall include a typed or legibly printed name, signature of the service provider and 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. 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 Licensed Practitioner of the Healing Arts (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 beneficiary is under age 21, or if a provider documents that the client is experiencing homelessness and therefore requires additional time to complete the assessment.
e. If a beneficiary withdraws from treatment prior to establishing a DSM diagnosis for Substance-Related and Addictive Disorders, and later returns, the 30-day or 60-day time period starts over. Assessments shall be updated as clinically appropriate when the beneficiary's condition changes. Additional information on assessment requirements can be found in BHIN 21-071 (DMC) and BHIN 21-075 (DMC-ODS).

(2) SMHS Assessment Domain Requirements

The SMHS assessment shall include the following seven required domains. Providers shall document the domains in the SMHS assessment and keep the assessment in the

beneficiary's medical record. Providers shall complete the assessment within a reasonable time and in accord with generally accepted standards of practice.

Domain 1:
- Presenting Problem(s)
- Current Mental Status
- History of Presenting Problem(s)
- Beneficiary-Identified Impairment(s)

Domain 2:
- Trauma

Domain 3:
- Behavioral Health History
- Comorbidity

Domain 4:
- Medical History
- Current Medications
- Comorbidity with Behavioral Health

Domain 5:
- Social and Life Circumstances
- Culture/Religion/Spirituality

Domain 6:
- Strengths, Risk Behaviors, and Safety Factors

Domain 7:
- Clinical Summary and Recommendations
- Diagnostic Impression
- Medical Necessity Determination/Level of Care/Access Criteria

(3) SMHS, DMC, and DMC-ODS Problem List

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

B. The problem list is a list of symptoms, conditions, diagnoses, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters.
C. A problem identified during a service encounter (e.g., crisis intervention) may be addressed by the service provider (within their scope of practice) during that service encounter, and subsequently added to the problem list.
D. The problem list shall be updated on an ongoing basis to reflect the current presentation of the beneficiary.
E. The problem list shall include, but is not limited to, the following:
    - Diagnoses identified by a provider acting within their scope of practice, if any.
        - Diagnosis-specific specifiers from the current DSM shall be included with the diagnosis, when applicable.
    - Problems identified by a provider acting within their scope of practice, if any.
    - Problems or illnesses identified by the beneficiary 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.
F. Providers shall add to or remove problems from the problem list when there is a relevant change to a beneficiary's condition.
G. 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 time and in accordance with generally accepted standards of practice.

(4) SMHS, DMC and DMC-ODS Progress Notes

A. 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.
B. Progress notes shall include:
    - The type of service rendered.
    - A narrative describing the service, including how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors).
    - The date that the service was provided to the beneficiary.
    - Duration of the service, including travel and documentation time.
    - Location of the beneficiary at the time of receiving the service.

- A typed or legibly printed name, signature of the service provider and date of signature.
- ICD 10 code.[3]
- Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code.
- Next steps including, but not limited to, planned action steps by the provider or by the beneficiary, collaboration with the beneficiary, collaboration with other provider(s) and any update to the problem list as appropriate.

C. Providers shall complete 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.

D. Providers shall complete a daily progress note for services that are billed on a daily basis, such as residential and day treatment services (including therapeutic foster care, day treatment intensive, and day rehabilitation). Weekly summaries will no longer be required for day rehabilitation and day treatment intensive.

E. When a group service is rendered, a list of participants is required to be documented and maintained by the plan or provider. Should more than one provider render a group service, one progress note may be completed for a group session and signed by one provider. While one progress note with one provider signature is acceptable for a group activity where multiple providers are involved, the progress note shall clearly document the specific involvement and the specific amount of time of involvement of each provider of the group activity, including documentation time. All other progress note requirements listed above shall also be met.

(5) Treatment and Care Planning Requirements

DHCS removed client plan requirements from SMHS and treatment plan requirements from DMC and DMC-ODS, with the exception of continued requirements specifically noted in Attachment 1. Several of these care plan requirements remain in effect due to applicable federal regulations or guidance.

A. Targeted Case Management (TCM)

Targeted case management services within SMHS require the development (and periodic revision) of a specific care plan that is based on the information collected

[3] For valid Medi-Cal claims, appropriate ICD-10 and HCPCS/CPT codes must appear in the clinical record, associated with each encounter and consistent with the description in the progress note. For further guidance on coding during the assessment process, refer to the Code Selection Prior to Diagnosis BHIN.

through the assessment. See the California State Plan, Sec. 3, Att. 3.1-A, Supp. 1, pp. 8-17; 42 C.F.R. § 440.169(d)(2) and 42 C.F.R. § 441.18 for more specific guidance. The TCM care plan:

- 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 beneficiary;
- Includes activities such as ensuring the active participation of the beneficiary, and working with the beneficiary (or the beneficiary's authorized health care decision maker) and others to develop those goals;
- Identifies a course of action to respond to the assessed needs of the beneficiary; and
- Includes development of a transition plan when a beneficiary has achieved the goals of the care plan.

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

B. Peer Support Services

Peer support services must be based on an approved plan of care.[4] The plan of care shall be documented within the progress notes in the beneficiary's clinical record and approved by any treating provider who can render reimbursable Medi-Cal services.

C. Additional Treatment and Care Plan Requirements

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

(6) Telehealth Consent

If a visit is provided through telehealth (synchronous audio or video) or telephone, the health care provider is required to confirm consent for the telehealth or telephone service, in writing or verbally, at least once prior to initiating applicable health care services via telehealth to a Medi-Cal beneficiary: an explanation that beneficiaries have the right to access covered services that may be delivered via telehealth through an in-person, face-to-face visit; an explanation that use of telehealth is voluntary and that

[4] State Medicaid Director Letter #07-011; California State Plan, Supp. 3 to Att. 3.1-A, pp. 4, 5, 6h, 6i (substance use disorder); p. 2m.1 (SMHS).

consent for the use of telehealth can be withdrawn at any time by the Medi-Cal beneficiary without affecting their ability to access covered Medi-Cal services in the future; an explanation of the availability of Medi-Cal coverage for transportation services to in-person visits when other available resources have been reasonably exhausted; and the potential limitations or risks related to receiving services through telehealth as compared to an in-person visit, to the extent any limitations or risks are identified by the provider. The provider must document in the patient record the provision of this information and the patient's verbal or written acknowledgment that the information was received.

IMPLEMENTATION:

Counties shall implement the documentation requirements established in this BHIN effective July 1, 2022. The implementation shall include updating policies and procedures, as well as supporting materials for triennial (SMHS) or annual (DMC/DMC-ODS) reviews to ensure compliance. Counties shall communicate these updates to providers as necessary.

COMPLIANCE MONITORING:

DHCS will continue to carry out its responsibility to monitor and oversee county SMHS, DMC, and DMC-ODS programs and their operations as required by state and Federal law. This oversight will include verifying that county and provider documentation complies with the requirements in this BHIN, that services provided to Medi-Cal beneficiaries are medically necessary, and that documentation complies with the applicable state and Federal laws, regulations, the MHP contract, DMC State Plan Contract, and the DMC-ODS Interagency Agreement/Contract.

Questions regarding this BHIN may be directed to BHCalAIM@dhcs.ca.gov.

Sincerely,

Original signed by

Shaina Zurlin, LCSW, PsyD, Chief
Medi-Cal Behavioral Health Division

Attachment 1: Requirements That Remain in Effect

Requirement	Authority / Background	Description
CalOMS	Data Collection Guide Data Compliance Standards Data Dictionary	CalOMS Treatment (CalOMS) is a data collection and reporting system for substance use disorder (SUD) treatment services.
CANS	MHSUDS IN 17-052 MHSUDS IN 18-007	The Child and Adolescent Needs and Strengths (CANS) is a structured assessment for identifying youth and family actionable needs and useful strengths.
PSC	MHSUDS IN 17-052	The Pediatric Symptom Checklist (PSC) is a psychosocial screening tool designed to facilitate the recognition of cognitive, emotional, and behavioral problems so that appropriate interventions can be initiated as early as possible.
CSI	MHSUDS IN 19-020	The Client and Service Information (CSI) system is a system used to collect encounter data for Medi-Cal and non-Medi-Cal clients for services provided in County or City Mental Health Plan programs.
ASAM	MHSUDS IN 18-046; BHIN 21-071; BHIN 21-075	The American Society of Addiction Medicine (ASAM) Criteria is a multidimensional assessment used to determine the appropriate level of care across a continuum.

Requirement	Authority / Background	Description
DATAR	45 C.F.R. § 96.126 DATAR Web User Manual	The Drug and Alcohol Treatment Access Report (DATAR) is a DHCS system used to collect data on substance use disorder treatment capacity and waiting lists.
PPSDS	Primary Prevention Substance Use Disorder Data Service Data Quality Standards	The Primary Prevention SUD Data Service (PPSDS) system is a system used by counties to collect and report their primary prevention substance use disorder program and activity data.
Discharge Plan Care Plan	42 C.F.R. § 482.43(a) W&I 14197.1; Health & Saf. Code, § 1367.01, subd. (h)(3)	When requested by the beneficiary's physician, a hospital must arrange for the development and implementation of a discharge plan for the beneficiary. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.
Care Plan	42 C.F.R. § 440.169(d) 42 C.F.R. § 441.18 California State Plan, Sec. 3, Att. 3.1-A, Supp. 1, pp. 8-17	TCM requires compliance with the cited Federal rules and State Plan. See (5)A of the BHIN for guidance on documenting these requirements in line with CalAIM documentation reform.

Requirement	Authority / Background	Description
Care Plan	42 C.F.R. § 440.169(d)(2) 42 C.F.R. § 441.18	Intensive Care Coordination (ICC) requires compliance with the cited Federal rules.
Care Plan	Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services, (IHBS), and Therapeutic Foster Care (TCF) Services for Medi-Cal Beneficiaries	Intensive Home Based Services (IBHS) and Therapeutic Foster Care (TFC) services for Medi-Cal Beneficiaries require a client plan.
Care Plan	DMH IN 08-38 Department of Mental Health Therapeutic Behavioral Services Coordination of Care Best Practices Manual	Therapeutic Behavioral Services (TBS) require a client plan.
Narcotic Treatment Program	42 C.F.R. § 8.12	Narcotic Treatment Programs (NTP) are required by Federal law to create treatment plans for their beneficiaries. Furthermore, NTP requirements for documentation and program requirements are not changing under this BHIN.

Requirement	Authority / Background	Description
Treatment Plan	Interim STRTP Regulations Version II, Section 10	A treatment plan is required for services provided in Short-Term Residential Therapeutic Programs (STRTPs).
Treatment Plan	CCR, tit. 22, § 77073	A treatment plan is required for services provided in Psychiatric Health Facilities (PHF).
Assessment and Treatment Plan	CCR, tit. 22, § 72451, subd. (e); 72471	A treatment plan is required for services provided in Special Treatment Programs within Skilled Nursing Facilities (STP-SNF).
Assessment Timeframes and Individual Service Plan	CCR, tit. 9, § 786.15, subds. (a), (g) CCR, tit. 9, §786.11 subds. (b)	A individual service plan is required for services provided in Mental Health Rehabilitation Centers (MHRCs).
Needs and Services Plan	CCR, tit. 9, § 1927, subds. (a)(6), (e)	A Needs and Services Plan (NSP) is required for services provided to children in Community Treatment Facilities.
Treatment/Rehabilitation Plan	CCR, tit. 9, § 532.2, subd. (c)	A treatment/rehabilitation plan is required for services provided in Social Rehabilitation Programs.
Plan of Care	Peer Support Services SPA 21-0051; SPA 21-0058; SPA 20-0006-A	Peer support services will be based on an approved plan of care. See section (5)B of this BHIN for guidance on documenting these requirements in line with CalAIM documentation reform.

Requirement	Authority / Background	Description
Physical Exam Requirements (DMC & DMC-ODS)	CCR, tit. 22, §51341.1 subd. (h)(1)(A)(IV)(a-c) except (c) requirements related to updated treatment plans; DMC-ODS IA requirements III.PP.11.i. and ii.	Physical exam requirements, timeframes, and documentation requirements are retained.
Diagnosis Documentation and Signature Requirements (DMC-ODS)	DMC-ODS IA Requirements III.PP.10.i.a.ii.	The Medical Director or LPHA shall type or legibly print their name, and sign and date the diagnosis narrative documentation. The signature shall be adjacent to the typed or legibly printed name.

Attachment 2: Superseded Regulations

Regulation Title and Section Number	**Superseded Part of Regulation**
Title 9 Section 1810.205.2 Client Plan	Superseded entirely.
Title 9 Section 1810.206 Collateral	Requirement that the needs of the beneficiary are understood “in terms of achieving the goals of the beneficiary's client plan” is superseded.
Title 9 Section 1810.232 Plan Development	Superseded entirely.
Title 9 Section 1810.440 MHP Quality management Programs	Subdivisions (c)(1)(A)-(C) and (c)(2)(A)-(B) are superseded.
Title 9 Section 1840.112 MHP Claims Certification and Program Integrity	Subdivision (b)(5) is superseded.
Title 9 Section 1840.314 Claiming for Service Functions-General	Subdivision (e)(2)’s requirements related to approval of client plans are superseded.
Title 22 Section 51341.1 Drug Medi-Cal Substance Use Disorder Services.	Subdivision (d)(2)’s requirements related to treatment planning are superseded.
Title 22 Section 51341.1 Drug Medi-Cal Substance Use Disorder Services.	Subdivision (d)(3)’s requirements related to treatment planning are superseded.
Title 22 Section 51341.1 Drug Medi-Cal Substance Use Disorder Services.	Subdivision (d)(4)’s requirements related to treatment planning are superseded.

Regulation Title and Section Number	**Superseded Part of Regulation**
Title 22 Section 51341.1 Drug Medi-Cal Substance Use Disorder Services.	Subdivision (d)(5)'s requirements related to treatment planning are superseded.
Title 22 Section 51341.1 Drug Medi-Cal Substance Use Disorder Services.	Subdivision (g)((1)(B)(ii) is superseded.
Title 22 Section 51341.1 Drug Medi-Cal Substance Use Disorder Services.	Subdivision (g)(2)(E) is superseded.
Title 22 Section 51341.1 Drug Medi-Cal Substance Use Disorder Services.	Subdivision (h)(1)(A)(iv)(c)'s requirements related to updated treatment plans are superseded.
Title 22 Section 51341.1 Drug Medi-Cal Substance Use Disorder Services.	Subdivision (h)(1)(A)(v)(b)'s requirements related to treatment plans are superseded.
Title 22 Section 51341.1 Drug Medi-Cal Substance Use Disorder Services.	Subdivision (h)(2)(A)(i) is superseded.
Title 22 Section 51341.1 Drug Medi-Cal Substance Use Disorder Services.	Subdivision (h)(2)(A)(ii)(a-c) is superseded.
Title 22 Section 51341.1 Drug Medi-Cal Substance Use Disorder Services.	Subdivision (h)(2)(A)(iii)(a-c) is superseded.

Regulation Title and Section Number	**Superseded Part of Regulation**
Title 22 Section 51341.1 Drug Medi-Cal Substance Use Disorder Services.	Subdivision (h)(3)(A-B) is superseded.
Title 22 Section 51341.1 Drug Medi-Cal Substance Use Disorder Services.	Subdivision (h)(3)(A)(ii)'s requirements related to treatment plans are superseded.
Title 22 Section 51341.1 Drug Medi-Cal Substance Use Disorder Services.	Subdivision (h)(3)(B)(i)'s requirements related to treatment plans are superseded.
Title 22 Section 51341.1 Drug Medi-Cal Substance Use Disorder Services.	Subdivision (h)(4)(A)(ii) is superseded.
Title 22 Section 51341.1 Drug Medi-Cal Substance Use Disorder Services.	Subdivision (h)(5)(A)(ii)(c)'s requirements related to treatment plans are superseded.
Title 22 Section 51341.1 Drug Medi-Cal Substance Use Disorder Services.	Subdivision (k)(3)'s requirements related to treatment plans are superseded.