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

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DATE: January 14, 2022

Behavioral Health Information Notice No: 22-XXX
Supersedes MHSUDS IN 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 Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS) services

REFERENCE: Welfare & Institutions (W&I) Code § 14184.402(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 Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS) services . These guidelines do not apply to nonspecialty behavioral health services in the Fee for Service and Medi-Cal managed care networks. These updated documentation requirements better align with Centers for Medicare and Medicaid Services (CMS) national coding standards and physical health care documentation practices. These updated standards will also be used when behavioral health payment reform is implemented.

The 2022-2023 Reasons for Recoupment will be updated to align with these documentation requirements.

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 Code sections 14184.100 et seq. Section 14184.402, subdivisions (h)(3) and (i)(1) give DHCS authority to develop and implement documentation standards through this Behavioral Health Information Notice (BHIN) until DHCS promulgates or amends regulations by July 1, 2024.

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 3, 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 2. All other regulations, contract terms, and BHINs or other guidance remain in effect.

**POLICY:**

**Overarching Policy**

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

DHCS has 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 2, and replaced them with these new behavioral health documentation requirements including a problem list and progress notes.

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.

**Standardized Assessment Requirements**

Counties shall require providers to use uniform assessment domains as described in Attachment 1 for adult SMHS. For beneficiaries under the age of 21, the Child and Adolescent Needs and Strengths (CANS) Assessment tool may be used to meet the requirements for assessment in lieu of the domains without further documentation. The time period for providers to complete an initial assessment and subsequent assessments for SMHS is up to clinical discretion; however, assessments shall be completed within a reasonable time and in accord with generally accepted standards of practice. The assessment shall include a typed or legibly printed name, signature of the service provider and date of signature. Providers shall determine that each service is medically necessary for the beneficiary based on the provider's assessment.

For DMC and DMC-ODS beneficiaries, the American Society of Addiction Medicine (ASAM) Criteria assessment shall be used. The assessment shall include a typed or legibly printed name, signature of the service provider and date of signature. Covered and clinically appropriate 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 DSM diagnosis for Substance-Related and Addictive Disorders 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. If a beneficiary withdraws from treatment prior to establishing a Diagnosis and Statistical Manual-5 (DSM) diagnosis for Substance-Related and Addictive Disorders, and later returns, the 30-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).

**Problem List**

A problem list shall be created and maintained for SMHS, DMC, and DMC-ODS beneficiaries by the provider(s) responsible for the beneficiary care. The problem list is a listing of symptoms, conditions, diagnoses, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters.

Each problem listed shall include the date of identification and the individual who identified the problem. Problems may be identified by providers within their respective scopes of practice and by the beneficiary and/or significant support person. 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. The problem list shall be updated on an ongoing basis to reflect the current presentation of the beneficiary.

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

- Diagnoses identified by a Licensed Practitioner of the Healing Arts (LPHA) acting within their scope of practice, if any.
- Problems identified by other providers acting within their respective scopes of practice, if any.
- Problems identified by the beneficiary and/or significant support person, if any.
- The name and title of the provider that added or removed the problem and the date the problem was added or removed.

SMHS, DMC, and DMC-ODS providers shall add to or remove problems from the problem list when there is a relevant change to a beneficiary's condition. Diagnosis-specific specifiers from the DSM-5 shall be included with the diagnosis, when applicable. 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 accord with generally accepted standards of practice.

**Progress Notes**

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. Progress notes shall include:

- The type of the 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 services were provided to the beneficiary.
- 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.
- International Classification of Diseases (ICD) 10 code.
- 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.

SMHS, DMC, and DMC-ODS 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.

SMHS, DMC, and DMC-ODS providers shall complete a daily progress note for services that are billed on a daily basis, such as residential and day treatment services (including day treatment intensive and day rehabilitation). Weekly summaries will no longer be required for day rehabilitation and day treatment intensive.

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 is done for a group session and may be 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 must 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 must also be met.

**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 review (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 and DMC programs and their operations as required by State and Federal law. This 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 is in compliance with the applicable State and Federal laws and regulations and the terms of 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,

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

Attachments

## *Attachment 1: SMHS Domain Description*

Each of the 7 domains identified in the first column are required components of the SMHS assessment, which shall be documented in the SMHS assessment and kept in the beneficiary's medical record. The assessment shall be completed within a reasonable time and in accord with generally accepted standards of practice.

Descriptions for each domain are set forth in the second column. The descriptions identified in the second column provide guidance for addressing each respective domain and are not a prescriptive or required list of elements.

For beneficiaries under the age of 21 the CANS assessment tool may be used to meet the requirements for assessment without further documentation.

| Domains | Description |
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| **Domain 1 requirements:**<br><br>**Presenting Problem(s)**<br>**Current Mental Status**<br>**History of Presenting Problem(s)**<br>**Beneficiary-Identified Impairment** | Chief complaint:<br>• Beneficiary-identified problem(s), history of the presenting problem(s), impact of problem(s) on beneficiary.<br>• Beneficiary's mental state at the time of the assessment.<br>• Impairment identified by the beneficiary including distress, disability, or dysfunction in an important area of life function. |
| **Domain 2 requirements:**<br><br>**Trauma** | History of trauma or exposure to trauma:<br>• Any psychological, emotional response to an event that is deeply distressing or disturbing. |

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| | • A measure of trauma by a trauma screening tool approved by the DHCS (e.g., Adverse Childhood Experiences screening tools), indicating elevated risk for development of a mental health condition.<br>• Experience with homelessness, juvenile justice involvement, or involvement in the child welfare system. |
| **Domain 3 requirements:**<br><br>**Behavioral Health History**<br>**Comorbidity** | Mental Health History:<br>• Acute and chronic conditions.<br>• Previous community-based treatment, including providers, therapeutic modality (e.g., medications, therapy, rehabilitative interventions, etc.) and response to interventions.<br>• Inpatient admissions.<br>• Crisis-based admissions.<br>Substance Use History:<br>• Exposure/substance use, including past and present use.<br>• Previous community-based treatment, including providers, therapeutic modality (e.g., medication-assisted treatment, rehabilitative interventions, etc.) and response to interventions.<br>• Inpatient psychiatric admissions.<br>• Intoxication/detox/withdrawal management-based admissions. |
| **Domain 4 requirements:**<br><br>**Medical History**<br>**Current Medications**<br>**Comorbidity with Behavioral Health** | Medical History:<br>• Relevant current or past physical health conditions.<br>• Prenatal and perinatal events, and relevant or significant developmental history.<br>• History of medications, medical treatments and responses.<br>Allergies to medications. |
| **Domain 5 requirements:** | Psychosocial factors:<br>• Living situation, daily activities, social support, and cultural and linguistic factors. |

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| **Social and Life Circumstances**<br>**Culture/Religion/Spirituality** | • Legal or justice-involved history.<br>• Family history and current family involvement.<br>• Military history.<br>• Tribal affiliation.<br>• LGBTQ.<br>• BIPOC. |
| **Domain 6 requirements:**<br><br>**Strengths, Risk Behaviors and Safety Factors** | Strengths, risk behaviors and protective factors:<br>• Strengths in achieving goals, including personal motivation, drive, and interest.<br>• Resilience and coping skills.<br>• Protective factors, including the availability of resources, opportunities, and supports (including support persons), interpersonal relationships, systems (family/, community/ professional), activities (routines/ social hobbies/ etc.).<br>• Situations and triggers that may induce risky behaviors.<br>• Suicidal/homicidal ideation.<br>Safety planning, including an individualized plan that can be self-initiated or initiated by a trusted person (e.g. sponsor). |
| **Domain 7 requirements:**<br><br>**Clinical Summary**<br>**ICD Code**<br>**Medical Necessity Determination**<br>**Level of Care/Access Criteria** | Clinical impression, including etiology, clinical complexity, and impairments:<br>• Predisposing, precipitating, perpetuating and protective factors.<br>• Diagnosis/ICD-code consistent with presenting problems, history, mental status exam and/or other clinical data, including any current medical diagnosis. Capture diagnostic uncertainty (provisional or unspecified).<br>• Service recommendations for the treatment episode.<br>Level of care determination for DMC and DMC-ODS (I.e., ASAM) and/or for SMHS (Access Criteria for SMHS found in BHIN21-073). |

## *Attachment 2: Requirements That Remain in Effect*

| Requirement | Authority / Background | Description |
|---|---|---|
| CalOMS | Data Collection Guide<br>Data Compliance Standards<br>Data Dictionary | CalOMS Treatment (CalOMS) is a data collection and reporting system for substance use disorder (SUD) treatment services. |
| CANS | MHSUDS IN 17-052<br>MHSUDS 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 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<br>BHIN 21-071<br>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. |

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| DATAR | 45 C.F.R. § 96.126<br><br>DATARWeb 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<br><br>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 | 42 C.F.R. § 482.43(a) | When requested by the beneficiary's physician, a hospital must arrange for the development and implementation of a discharge plan for the beneficiary. |
| Care Plan | 42 C.F.R. § 440.169(d)(2) | Federal law requires a care plan for individuals receiving case management services. A care plan is required for Targeted Case Management services, including Intensive Care Coordination. |
| 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. |
| Treatment Plan | Interim STRTP Regulations Version II, Section 10 | A treatment plan is required for services provided in Short-Term Residential Therapeutic Programs (STRTPs). |

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| 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) and 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, subd. (a) | A individual service plan is required for services provided in Mental Health Rehabilitation Centers (MHRCs). |
| Needs and Services Plan | CCR, tit. 9, § 1927, subd. (a)(6) | A Needs and Services Plan (NSP) is required for services provided to children within 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 | Peer support services will be based on an approved plan of care. |
| Treatment Planning | Section 7090 AOD Certification Standards | AOD Certified programs shall develop treatment plans in accordance with Section 7090 of the AOD Certification Standards. |
| 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. |

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| 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 3: Superseded Regulations*

| **Regulation Title and Section Number** | **Superseded Part of Regulation** |
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| 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. |

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| 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. |
| Title 22 Section 51341.1 Drug Medi-Cal Substance Use Disorder Services. | Subdivision (h)(3)(A-B) is superseded. |

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| 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. |