

County of Marin Behavioral Health and Recovery Services (BHRS)	POLICY NO. BHRS-25
POLICY: <u>DOCUMENTATION REQUIREMENTS FOR ALL SPECIALITY MENTAL HEALTH SERVICES (SMHS), DRUG MEDI-CAL (DMC), AND DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM (DMC-ODS) SERVICES</u>	Next Review Date: January 2027 Date Approved: January 1, 2024 Date Reviewed/Approved: By:  Todd Schirmer, PhD, CCHP Director of Behavioral Health and Recovery Services

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

I. PURPOSE:

This policy and procedure updates chart documentation requirements for most all Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC) and Drug Medi-Cal Organized Delivery System (DMC-ODS) services. The information in this policy and procedure supersedes guidance from the Department of Health Care Services’ (DHCS) Information Notice 22-019.

II. REFERENCES:

Behavioral Health Information Notice 23-068
 Welfare and Institutions Code (W&I) 14184.402. subd. (h)93)

III. 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 updated documentation requirements better align with Centers for Medicare and Medicaid Services’ (CMS) national coding standards and physical health care documentation practices.

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IV. POLICY:

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 corrective action plans. Recoupment shall be focused on fraud, waste, and abuse.¹

To the extent that there is conflict between the Mental Health Plan (MHP) contract, DMC contract, or the DMC-ODS Intergovernmental Agreement terms and this BHIN, the policy contained within supersedes the contract terms.

If there is a conflict between Enclosure 1a requirements and the documentation requirements within this policy, then the Enclosure 1a requirements supersede the requirements within this policy. When no conflict exists, documentation must comply with both Enclosure 1a requirements and the documentation requirements within this policy.

SMH, DMC, and DMC-ODS 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.

Applicability

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

- Narcotic Treatment Programs,
- Psychiatric inpatient services provided in hospitals, Psychiatric Health Facilities, or Psychiatric Residential Treatment Facilities, and
- DMC-ODS inpatient services provided in Chemical Dependency Recovery Hospitals and acute psychiatric hospitals.

¹ Fraud and abuse are 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.

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V. **PROCEDURE:**

(a) **Standardized Assessment Requirements**

1) **Timely assessments: SMHS, DMC, and DMC-ODS**

- i. 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.²
- ii. Assessments shall be updated as clinically appropriate, such as when the member’s condition changes.
- iii. As part of a Medi-Cal behavioral health delivery system’s Quality Assessment and Performance Improvement 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.
- iv. 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

² Some SMHS and DMC/DMC-ODS services, such as residential levels of care, are subject to licensure or certification requirements that include additional standards for member assessments. Such standards remain in effect unless DHCS supersedes them. Please see Enclosure 1b for references to some assessment standards that remain in effect (this Enclosure may not be an exhaustive list). In some cases, this policy seeks to clarify how assessment standards tied to licensure or certification relate to the comprehensive Medi-Cal SMHS and DMC/DMC-ODS assessment requirements in this policy.

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the member does not meet the access criteria for the delivery system in which they initially sought care.³

(2) SMHS, DMC, and DMC-ODS Crisis Assessments

- i. Crisis assessments completed during the provision of SMH crisis intervention or crisis stabilization, or a SMH, 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 SMH, DMC, or DMC-ODS services, an assessment shall be completed in accordance with the requirements in this policy.

(A) For assessment and documentation requirements specific to Medi-Cal Mobile Crisis Services, please refer to [BHIN 23-025](#).

(3) DMC and DMC-ODS Assessments

- i. The Medi-Cal documentation guidance in this policy does not change or supersede existing requirements for DHCS Level of Care (LOC) Designations for providers of Residential Treatment Services or Withdrawal Management Services. As described in DHCS’ LOC 3 Designation requirement⁴:

A) Providers of Residential Treatment Services shall ensure each member receives a multidimensional LOC assessment within 72 hours of admission.⁵

(B) A resident receiving Withdrawal Management services is exempt from the requirement to conduct a multidimensional assessment

³ For additional information on this policy please refer to BHIN 21-071; BHIN 21-073; BHIN 22-011; BHIN 23-001; or subsequent guidance. For information on diagnostic coding during the assessment refer to BHIN 22-013.

⁴ See BHIN 21-001 Exhibit A, or subsequent Level of Care certification guidance.

⁵ This initial Level of Care assessment for residential treatment should be used to ensure the member has been admitted into the right level of care but need not meet the comprehensive ASAM assessment requirements described in this policy. Following the initial Level of Care assessment, a comprehensive assessment should be completed as expeditiously as possible, in accordance with each member’s clinical needs and generally accepted standards of practice.

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within 72 hours of admission, as described in Exhibit A of BHIN 21-001 or subsequent DHCS LOC Designation guidance.

- ii. Licensed or certified SUD recovery or treatment programs are required to conduct evidence-based assessments of clients' 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 described in this policy.
- iii. Medi-Cal behavioral health delivery systems shall require providers to use an American Society of Addiction Medicine (ASAM) Criteria assessment for DMC and DMC-ODS members.⁶
- iv. Medi-Cal behavioral health delivery systems shall accept an ASAM assessment completed by a qualified provider using either the free⁷ ASAM Criteria Assessment Interview Guide or ASAM CONTINUUM software.
- v. Effective January 1, 2025, DMC and DMC-ODS providers shall use one of the ASAM assessment tools described in (iv) above or a validated tool subsequently approved by DHCS and added to the list of approved DMC and DMC-ODS ASAM assessment tools.⁸
- vi. The assessment shall include the licensed provider's recommendations for ASAM Level of Care and medically necessary services, and additional provider referrals, as clinically appropriate.
- vii. The problem list and progress note requirements identified below shall support the medical necessity of each service provided.
- viii. Both licensed and non-licensed providers, including those not qualified to diagnose an SUD, may contribute to the assessment consistent with their scopes of practice, as described in the State Plan.⁹
- ix. If the assessment of the member is completed by a registered or certified counselor, then a Licensed Practitioner of the Healing Arts (LPHA) shall

⁶ W&I § 14184.402(a), (e), and (i).

⁷ The free ASAM Criteria® Assessment Interview Guide may be integrated within an Electronic Health Record and need not be paper based.

⁸ DHCS will provide additional guidance and technical assistance as needed to address questions about how approved tools may and may not be modified when integrated into an Electronic Health Record.

⁹ California State Plan, Sec. 3, Att. 3.1-A, Supp. 3; California State Plan, Section 3, Att. 3.1-B, Supp. 3.

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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.

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

(4) SMHS Assessments

- i. MHPs shall require providers to use uniform assessment domains as identified in section (b) of this policy. The assessment may be in any format so long as the assessment domains and components are included, and the assessment information is comprehensive, consolidated, and can be produced and shared as appropriate to support coordinated care, in accordance with applicable state and federal privacy laws.
- ii. The assessment shall include the licensed provider’s recommendations for medically necessary services and additional provider referrals, as clinically appropriate.
- iii. The problem list and progress note requirements identified in this policy shall support the medical necessity of each service provided.
- iv. The diagnosis, current mental status, 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 within their scope of practice under California state law, who is licensed, registered, waived, and/or under the direction of a licensed mental health professional as defined in the State Plan.¹⁰
- v. 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, as described in the State Plan.¹¹

¹⁰ California State Plan, Sec. 3, Att. 3.1-A, Supp. 3.

¹¹ California State Plan, Sec. 3, Att. 3.1-A, Supp. 3; California State Plan Section 3, Att. 3.1-B, Supp. 2.

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- vi. The assessment shall include a typed or legibly printed name, signature of the service provider, provider title (or credentials), and date of signature.
- vii. 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 inform the assessment domain requirements. An initial CANS shall be completed or an existing CANS shall be updated by a CANS certified provider. For additional guidance on CANS requirements, please refer to MHSUDS IN 17-052 and MHSUDS IN 18-007.

(b) SMHS Assessment Domain Requirements

(1) For the purposes of this policy, a domain is a reference to categories of information that should be captured within the SMHS assessment. To the extent the information is available, all components listed within each of the seven domains shall be included as part of a comprehensive assessment.

Domain 1:

Presenting Problem(s)
Current Mental Status
History of Presenting Problem(s)
Member-Identified Impairment(s)

Domain 2:

Trauma

Domain 3:

Behavioral Health History
Co-occurring Substance Use

Domain 4:

Medical History
Current Medications
Co-occurring Conditions (other than substance use)

Domain 5:

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Social and Life Circumstances
Culture/Religion/Spirituality

Domain 6:
Strengths, Risk Behaviors, and Protective Factors

Domain 7:
Clinical Summary and Recommendations
Diagnostic Impression
Medical Necessity Determination/LOC/Access Criteria

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

1. The provider(s) responsible for the member's care shall create and maintain a problem list.
2. 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.
 - (A) Diagnosis-specific specifiers from the current Diagnostic and Statistical Manual of Mental Disorders shall be included with the diagnosis, when applicable.
 - (ii) Current International Classification of Diseases (ICD) Clinical Modification (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.
 - (v) The name and title (or credentials) of the provider that identified, added, or resolved the problem, and the date the problem was identified, added, or resolved.

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3. A problem identified during a service encounter (e.g., crisis intervention encounter) may be addressed by the service provider (within their scope of practice) during that service encounter, and subsequently added to the problem list.
4. The problem list shall be updated on an ongoing basis to reflect the current presentation of the member. Providers, within their scopes of practice, shall add to, amend, or resolve problems from the problem list when there is a relevant change to a member's condition.
 - a. 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.
5. For members that were receiving services prior to July 1, 2022 (the date that problem list requirements first took effect), a problem list is not required to be created retroactively. However, a problem list should be started when the member receives a subsequent SMH, DMC, or DMC-ODS service after July 1, 2022.

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

- (1) Providers shall create progress notes for the provision of all Medi-Cal behavioral health delivery system services. Each progress note shall provide sufficient detail to support the service code(s) selected for the service type(s) as indicated by the service code description(s).¹²
 - (i) 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

¹² For valid Medi-Cal claims, appropriate ICD-CM diagnostic codes, as well as HCPCS/CPT codes, must appear in the claim and must also be clearly associated with each encounter and consistent with the description in the progress note. However, current ICD-CM codes and HCPCS/CPT codes are not required to be included in the progress note narrative. For further guidance on use of ICD-10 codes during the assessment process, refer to BHIN 22-013: Code Selection Prior to Diagnosis.

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least one provider. The progress note shall clearly document the specific involvement and duration of direct patient care for each provider of the service.

(2) Progress notes for all non-group services shall include:

- (i) The type of service rendered.
- (ii) The date that the service was provided to the member.
- (iii) Duration of direct patient care for the service¹³
- (iv) Location/place of service.
- (v) A typed or legibly printed name, signature of the service provider, and date of signature.
- (vi) A brief description of how the service addressed the member’s behavioral health needs (e.g., symptom, condition, diagnosis, and/or risk factors).¹⁴
- (vii) A brief summary of next steps.¹⁵

(3) For group services:

- (i) When a group service is rendered, a list of participants is required to be documented and maintained by the provider.
- (ii) Every participant shall have a progress note in their clinical record that documents the service encounter and their attendance in the group, and includes the information listed in (2)(i-v) above.
- (iii) The progress note for the group service encounter shall also include a brief description of the member’s response to the service.¹⁶

(4) Generally speaking, the contents of the progress note shall support the service code(s) selected and support effective clinical care and

¹³ Direct patient care time is defined in the SMHS and DMC/DMC-ODS billings manuals; see <https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx>.

¹⁴ For example, as clinically indicated the brief description may include activities or interventions that occurred during the service event; issues discussed; and progress toward treatment goals or other treatment outcomes.

¹⁵ For example, as clinically indicated next steps may include planned action steps by the provider or by the member; collaboration with the member; collaboration with other provider(s); goals and actions to address health, social, educational, and other services needed by the member; referrals; and discharge and continuing care planning.

¹⁶ For example, as clinically indicated the individual note for a group service may address the effectiveness of the intervention; progress or problems noted; group dynamics; or other information relevant to the member’s participation, comments, or reactions during the treatment session.

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coordination among providers. Notes shall include the minimum elements described in (2) or (3) above, but the nature and extent of the information included may vary based on the service type and the member’s clinical needs. Some notes may appropriately contain less descriptive detail than others.¹⁷ If information is located elsewhere in the clinical record (for example, a treatment plan template), it does not need to be duplicated in the progress note.

(5) Providers shall complete progress notes within three (3) business days of providing a service, with the exception of notes for crisis services, which shall be completed within one (1) calendar day. The day of the service shall be considered day zero (0).

(6) Providers shall complete at minimum a daily progress note for services that are billed on a daily basis (i.e., bundled services), such as Crisis Residential Treatment, Adult Residential Treatment, DMC/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 second, unbundled service.

(e) Care Planning Requirements

DHCS no longer requires prospectively completed, standalone client plans for Medi-Cal SMHS, or prospectively completed, standalone treatment plans for DMC and DMC-ODS services. The intent of this change is to affirm that care planning¹⁸ is an ongoing, interactive component of service delivery rather than a one-time event. Where possible, DHCS has modified, or may modify, state-level requirements for care, client, service, and treatment plans (hereafter referred to as “care plans”) to eliminate additional care planning specifications and align with the Medi-Cal requirements described in this policy.

¹⁷ For example, a group note for a participant that chose not to speak during the group service may not include the same level of detail as a note for a group participant who engaged more actively, or a note for an individual counseling or therapy session.

¹⁸ For purposes of this policy, the terms “care planning” and “care plans” are used as general terms to describe the activities and requirements listed in Enclosure 1a, inclusive of references to “client plans,” “treatment plans,” or “service plans” that appear in other state or federal authorities.

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There are some programs, services, and facility types for which federal or state law continues to require the use of care plans and/or specific care planning activities (see Enclosure 1a). For SMH, DMC, and DMC-ODS services, programs, or facilities for which care plan requirements remain in effect:

- (1) Providers must adhere to all relevant care planning requirements in state or federal law.
- (2) The provider shall 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.
- (3) To support delivery of coordinated care, the provider shall 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.
- (4) Medi-Cal behavioral health delivery systems shall not enforce requirements for the location, format, or other specifications for documentation of the care plan that differ from those described within this policy and referenced in its Enclosures.

VI. 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 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

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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 medical record the provision of this information and the client’s verbal or written acknowledgment that the information was received.

DEFINITIONS

Drug Medi-Cal (DMC): Drug Medi-Cal is a treatment funding source for eligible Medi-Cal members. In order for Drug Medi-Cal to pay for covered services, eligible Medi-Cal members must receive substance use disorder (SUD) services at a Drug Medi-Cal certified program. SUD services funded by Drug Medi-Cal 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.

Drug Medi-Cal Organized Delivery System (DMC-ODS): The Drug Medi-Cal Organized Delivery System (DMC-ODS) provides a continuum of care modeled after the American Society of Addiction Medicine Criteria for substance use disorder 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 beneficiary 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, dental managed care, and Specialty Mental Health Services (SMHS).

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 beneficiaries. 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.

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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 specialty mental health services (SMHS).

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 EPSDT, regardless of level of distress or impairment or the presence of a diagnosis, and recipients of any age with potential mental health disorders not yet diagnosed.

Specialty Mental Health Services (SMHS): SMHS include but are not limited to: Assessment, Plan Development, Rehabilitation Services, Therapy Services, Collateral, 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 beneficiaries through County Mental Health Plans (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.

FORMS/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

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Enclosure 1a: Care Planning Requirements that Remain in Effect

This Enclosure provides guidance to Medi-Cal behavioral health delivery systems on specific standards for care planning that remain in effect under state or federal law (including secondary guidance like policy or practice manuals). It may not be an exhaustive list of all relevant state or federal requirements, and the guidance it cites may be subject to changes. Member records for programs, services, and facilities that are subject to care planning requirements cited in this Enclosure must comply with all applicable care planning requirements. Care planning may be documented as described above in this BHIN, with required care plan elements documented within the member record. For example, 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. While DHCS does not require a specific format or location for care plan information, to support delivery of coordinated care the provider shall 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. Generally speaking, documentation shall comply with both Enclosure 1a requirements (which may be more specific than the requirements above in this BHIN) and the standards in this BHIN. DHCS will provide technical assistance as needed to clarify how compliance will be monitored for Enclosure 1a services, programs, and facilities.

Program, Service, or Facility Type	Authority/ Background
Children’s Crisis Residential Programs (CCRP)	Children’s Crisis Residential Mental Health Program Interim Standards
Community Treatment Facilities (CTF)	9 CCR § 1927, subs. (a)(6), (e)
DMC-ODS Residential Treatment Services and Withdrawal Management Services provided in DHCS LOC designated AOD Treatment Facilities	BHIN 21-001 and attachments
Enhanced Care Management (ECM) ²⁰	ECM Policy Guide
Mental Health Rehabilitation Centers (MHRC)	9 CCR § 786.15, subs. (a), (d), (e)
Mental Health Services Act Full-Service Partnership (FSP) Individual Services and Supports Plan (ISSP)	9 CCR § 3620

²⁰ This service is covered through Medi-Cal Managed Care Plans (MCPs), not Medi-Cal behavioral health delivery systems. However, it is included here for ease of reference, given many specialty behavioral health clients are eligible to receive ECM and specialty behavioral health plans or network providers may contract with MCPs to provide this service.

Peer Support Services	CMS Directors' Letter 07-011; California State Plan, Sec. 3, Att. 3.1-A, Supp. 3; California State Plan Section 3, Att. 3.1-B, Supps. 2, 3
Short-Term Residential Therapeutic Programs (STRTPs)	Interim STRTP Regulations Version II, Section 10
Social Rehabilitation Programs (SRPs). Includes programs certified by DHCS for: <ul style="list-style-type: none"> • Short-Term Crisis Residential Treatment; • Transitional Residential Treatment; and • Long Term Residential Treatment 	9 CCR § 532.2, subds. (c), (d)
Substance Abuse Block Grant (SABG) Programs/Services ²¹	45 CFR § 96.136(d)(3)
Targeted Case Management (TCM); Intensive Care Coordination (ICC) ^{22,23}	42 CFR § 440.169(d)(2)
Therapeutic Behavioral Services (TBS) ²⁴	DMH IN 08-38; Emily Q. v. Bonta, Nine-Point Plan (Appendix D).

²¹ SABG treatment planning may be documented in the manner described in this BHIN. Federal regulations that apply to services funded with federal Substance Abuse Block Grants refer to treatment planning activities, but do not specify that treatment planning must be documented in any specific format or location.

²² TCM and ICC care planning may be documented in the manner described in this BHIN. The Centers for Medicare and Medicaid Services (CMS) has approved the following: "DHCS' new documentation standards outlined in BHIN 22-019, or any subsequent guidance require providers to incorporate the TCM care plan elements outlined in 42 CFR § 440.169(d)(2) into the clinical record. Under the new standards for SMHS, care planning is documented through a treatment plan or a combination of the assessment record, a problem list, progress notes, or another section of the clinical record for each encounter." (Section 1915(b) Waiver Proposal for California Advancing and Innovating Medi-Cal (CAAIM), Amendment Submitted November 4, 2022, Updated June 23, 2023).

²³ Requirements for ICC care planning are also discussed in the [Medi-Cal Manual for ICC, IHBS, and TFC Services for Medi-Cal Beneficiaries](#). The ICC requirements in this manual were developed to be consistent with the TCM requirements in federal regulation cited in this Enclosure. Federal requirements applicable to ICC care planning remain in effect and must be observed. DHCS will not enforce the use of a care plan, or specific care planning requirements, as part of compliance monitoring specific to IHBS or TFC (however, children receiving these services are likely to have a care plan developed as part of ICC).

²⁴ Court documentation for *Emily Q. v. Bonta* is [available via DHCS' website](#).

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

This Enclosure was developed to provide guidance to Medi-Cal behavioral health delivery systems on additional service delivery, data reporting, or documentation standards that remain in effect under state or federal law (including secondary guidance like policy or practice manuals). Unlike Enclosure 1a, these requirements are not limited to care planning. To the extent that these authorities reference clinical documentation, DHCS will provide technical assistance as needed to clarify how compliance will be monitored. This Enclosure is not an exhaustive list of all relevant state or federal requirements, and the guidance it cites may be subject to changes.

Requirement	Authority/ Background
Adolescent Substance Use Disorder Services <ul style="list-style-type: none"> Generally speaking, these guidelines remain in effect. DHCS will not enforce the use of a care plan or specific care planning requirements for adolescent SUD services. 	Adolescent Substance Use Disorder Best Practices Guide
American Society of Addiction Medicine (ASAM)	MHSUDS IN 18-046; BHIN 21-071; BHIN 23-001 (or subsequent guidance)
CalOMS Treatment (CalOMS)	Data Collection Guide; Data Compliance Standards; Data Dictionary
Certification of Alcohol and Other Drug Programs	HSC § 11832 ; See forthcoming BHIN and enclosure(s)
Child and Adolescent Needs and Strengths (CANS)	MHSUDS IN 17-052; MHSUDS IN 18-007
Children’s Crisis Residential Programs (CCRP) <ul style="list-style-type: none"> See standards for assessment and other service activities. Standards for CCRP care planning are addressed in Enclosure 1a. 	Children’s Crisis Residential Mental Health Program Interim Standards
Client and Service Information (CSI)	MHSUDS IN 19-020
Community Treatment Facilities (CTF) <ul style="list-style-type: none"> See standards for assessment and other service activities. Standards for CTF care planning are addressed in Enclosure 1a. 	9 CCR § 1927
Drug and Alcohol Treatment Access Report (DATAR)	45 CFR § 96.126 DATAR Web User Manual

<p>DHCS LOC Designations for AOD Treatment Facilities (applies to DMC/DMC-ODS Providers of Residential Treatment Services and Withdrawal Management Services)</p>	<p>BHIN 21-001 and attachments</p>
<p>Enhanced Care Management (ECM)²⁵</p> <ul style="list-style-type: none"> See Policy Guide for ECM-specific service delivery, documentation, and reporting standards. Standards for ECM care planning are addressed in Enclosure 1a. 	<p>ECM Policy Guide</p>
<p>Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), Therapeutic Foster Care (TFC)</p> <ul style="list-style-type: none"> See general standards for service delivery. Care planning requirements specific to ICC are addressed in Enclosure 1a. DHCS will not enforce the use of a care plan or specific care planning requirements for IHBS or TFC. 	<p>Medi-Cal Manual for ICC, IHBS, and TFC Services for Medi-Cal Beneficiaries</p>
<p>Mental Health Rehabilitation Centers (MHRC)</p> <ul style="list-style-type: none"> See standards related to assessment and other service activities. Standards for MHRC care planning are addressed in Enclosure 1a. 	<p>9 CCR § 786.11, subd. (b) 9 CCR § 786.15</p>
<p>Physical Exam Requirements (DMC & DMC-ODS)</p>	<p>22 CCR § 51341.1, subd. (h)(1)(A)(iv)(a-c)</p>
<p>Primary Prevention SUD Data Service (PPSDS)</p>	<p>Primary Prevention SUD Data Service Data Quality Standards</p>
<p>Pediatric Symptom Checklist (PSC)</p>	<p>MHSUDS IN 17-052</p>
<p>Perinatal Substance Use Disorder Services</p> <ul style="list-style-type: none"> Generally speaking, these guidelines remain in effect. DHCS will not enforce the use of a care plan or specific care planning requirements for perinatal SUD services. 	<p>Perinatal Practice Guidelines</p>

²⁵ This service is covered through Medi-Cal Managed Care Plans (MCPs), not Medi-Cal behavioral health delivery systems. However, it is included here for ease of reference, given many specialty behavioral health clients are eligible to receive ECM and specialty behavioral health plans or network providers may contract with MCPs to provide this service.

<p>Short-Term Residential Therapeutic Programs (STRTPs)</p> <ul style="list-style-type: none"> • See standards for assessment and other service activities. Standards for STRTP care planning are addressed in Enclosure 1a. 	<p>Interim STRTP Regulations Version II, Section 10</p>
<p>Social Rehabilitation Programs (SRPs)</p> <ul style="list-style-type: none"> • See standards related to assessment and other service activities. Standards for care planning for SRPs that hold DHCS certifications for short-term, transitional, or long-term residential treatment are addressed in Enclosure 1a. 	<p>9 CCR § 532.2, subds. (b), (g)</p>

Enclosure 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 member are understood "in terms of achieving the goals of the member'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 SUD Services.	Subdivision (d)(2)'s requirements related to treatment planning are superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (d)(3)'s requirements related to treatment planning are superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (d)(4)'s requirements related to treatment planning are superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (d)(5)'s requirements related to treatment planning are superseded.

Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (g)(1)(B)(ii) is superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (g)(2)(A-E) is superseded. Sign-in sheets are no longer required for DMC/DMC-ODS group counseling; however, the provider must maintain a participant list as described above in the body of this BHIN.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (h)(1)(A)(iv)(c)'s requirements related to updated treatment plans are superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (h)(1)(A)(v)(a-b)'s requirements related to diagnosis and evaluation of a substance use disorder within 30 days of admission to treatment. Note: only the timeline is superseded, not the requirement to diagnose and evaluate the member.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (h)(1)(A)(v)(b)'s requirements related to treatment plans are superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (h)(2)(A)(i) is superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (h)(2)(A)(ii)(a-c) is superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (h)(2)(A)(iii)(a-c) is superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (h)(3)(A-B) is superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (h)(3)(A)(ii)'s requirements related to treatment plans are superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (h)(3)(B)(i)'s requirements related to treatment plans are superseded.

Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (h)(4)(A)(ii) is superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (h)(5)(A)(i-iii) is superseded.
Title 22 Section 51341.1 Drug Medi-Cal SUD Services.	Subdivision (k)(3)'s requirements related to treatment plans are superseded.