

CALIFORNIA COUNTIES TREATMENT RECORD REQUIREMENTS

Every service provided is subject to ValueOptions, State of California and federal audits. All treatment records must include documentation of all elements specified in the “Medical Necessity Criteria” section of this document as required by Medi-Cal (to view the complete regulation, see the California Code of Regulations [CCR] Title 9 1830.205 and 1830.210 for additional information).

Failure to document all required medical necessity elements and to comply with specified timelines for development of initial client treatment plan and annual completion or update of the client plan may result in a claims reversal.

Provider participation in random treatment record audits is an integral part of ValueOptions’ quality management program and is a condition of network participation.

Covered Services

Covered services under the full scope Medi-Cal program for outpatient specialty mental health services are listed below.

At times, the County may decide to manage the care of an individual member, even though the member is placed outside their home county. This is at the discretion of the County. In cases where this occurs, all treating providers will be notified.

Please note: In order for a beneficiary to receive benefits under the plan, the beneficiary must meet medical necessity criteria and be eligible for benefit coverage. All services must be pre-authorized.

CPT Codes	Description	Licensed Psychiatrist	Licensed Professional Therapist
90801	Psychiatric diagnostic interview examination	Reimbursable	Reimbursable
90806	Individual psychotherapy, in an office or outpatient facility, approximately 45-50 minutes	Reimbursable	Reimbursable
90807	Individual Psychotherapy with Pharmacological Management, approximately 45-50 minutes	Reimbursable	Not Reimbursable
90847	Family psychotherapy (conjoint)	Reimbursable	Reimbursable
90853	Group psychotherapy	Reimbursable	Reimbursable
90862	Pharmacologic management	Reimbursable	Not Reimbursable
96101	Psychological testing, with interpretation	Reimbursable	Reimbursable

	and report, per hour		
99361	Case Conference – 30 minutes	Reimbursable-Documentation must support this activity in detail.	Reimbursable - Documentation must support this activity in detail.
99362	Case Conference – 60 minute	Reimbursable-Documentation must support this activity in detail.	Reimbursable-Documentation must support this activity in detail.

Medical Necessity Criteria

Medical Necessity criteria must be clearly documented in the medical record. Medical necessity for specialty mental health services must have all, A, B, and C:

A. *Diagnoses* – Must have one of the following DSM IV diagnoses which will be the focus of the intervention provided:

- Pervasive Developmental Disorders, except Autistic Disorder which is excluded
- Attention Deficit & Disruptive Behavior Disorders
- Feeding & Eating Disorders of Infancy or Early Childhood
- Elimination Disorders
- Other Disorders of Infancy, Childhood or Adolescence
- Schizophrenia & other Psychotic Disorders, except psychotic disorders due to a General Medical Condition
- Mood Disorders, except mood disorders due to a General Medical Condition
- Anxiety Disorders, except anxiety disorders due to a General Medical Condition
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Paraphilias
- Gender Identity Disorders
- Eating Disorders
- Impulse-Control Disorders, not elsewhere classified
- Adjustment Disorders
- Personality Disorders, excluding Antisocial Personality Disorder
- Medication-Induced Movement Disorders related to other included diagnoses

B. *Impairment Criteria* – Must have one of the following as a result of the mental disorder(s) identified in the diagnostic (“A”) criteria: Must have one 1,2 or 3:

1. A significant impairment in an important area of life functioning, *or*,
2. A reasonable probability of significant deterioration in an important area of life functioning, *or*,

3. Children also qualify if there is a probability the child will not progress developmentally as individually appropriate. Children covered under EPSDT qualify if they have a mental disorder, which can be corrected or ameliorated.

C. *Intervention Related Criteria* – Must have all 1, 2 & 3:

1. The focus of proposed intervention is to address the condition identified in Impairment Criteria (“B”) above, and
2. It is expected the beneficiary will benefit from the proposed intervention by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning. Moreover, for children it is probable the child will progress developmentally as individually appropriate (or if covered by EPSDT can be corrected or ameliorated), *and*
3. The condition would not be responsive to physical health care based treatment.

D. *Excluded Diagnoses* – A beneficiary may receive services for an included diagnosis even though an excluded diagnosis may also be present:

- Mental Retardation
- Learning Disorders
- Motor Skills Disorder
- Communication Disorders
- Autistic Disorder, other Pervasive Developmental Disorders are included
- Tick Disorders
- Delirium, Dementia & Amnestic & Other Cognitive Disorders
- Mental Disorders due to a General Medical Condition
- Substance-related Disorders
- Sexual Dysfunctions
- Sleep Disorders
- Antisocial Personality Disorder
- Other conditions that may be a focus of Clinical Attention, except Medication Induced Disorders which are included

See the California Code of Regulations (CCR) Title 9 1830.205 and 1830.210 for additional information.

Treatment Records

You are required to maintain member records in compliance with the policies and procedures of ValueOptions and the State of California Medi-Cal regulations. ValueOptions adheres to standards of accrediting organizations such as the National Committee for Quality Assurance (NCQA), Utilization Review Accreditation Commission (URAC) and federal and state regulations. These standards require that "patient records are maintained in a manner that is current, comprehensive, detailed, organized and legible to promote effective patient care and quality review."

Treatment Planning

ValueOptions' providers are required to develop individualized treatment plans that use assessment data, address the member's current problems related to the covered DSM-IV TR diagnosis, and actively include the member/guardian and significant others, as appropriate, in the treatment planning process. Treatment plans shall:

1. Describe the active target interventions with specific measurable goals and objectives,
2. Reflect the use of relevant therapies,
3. Show appropriate involvement of pertinent community agencies,
4. Demonstrate discharge planning from the time of admission, and
5. Reflect active involvement of the member/guardian and significant others as appropriate,
6. Be completed within 60 days of intake.

Providers are expected to document progress toward meeting goals and objectives in the treatment record and to review and revise treatment plans as appropriate. Please note that there are required timelines for the initial development and review of the treatment plan. **Also note that, according to the medical necessity criteria, each member must have an allowable diagnosis, and that chart documentation must include:**

1. As a result of member's mental disorder, the member has: a) a significant impairment in an important area of life functioning, or b) a probability of significant deterioration in an important area of life functioning, or c) a probability the child will not progress developmentally as appropriate.
2. An intervention to address the impairment identified in 1, above, and that the proposed intervention is expected to diminish the impairment, prevent deterioration, or allow a child to progress developmentally.
3. Evidence of the member/guardian involvement in the development of tx goals; treatment plan is signed by the member/guardian; if refused, includes explanation, and that a copy of the treatment plan has been provided.
4. While timelines for completion of the initial treatment plan and annual reviews may vary by county, **an initial treatment plan must be completed within 60 days of intake** unless there is documentation supporting the need for more time. The member's **treatment plan must be completed/updated at least annually.**
5. In addition, each client contact must reflect documentation of the session date, the session type (individual, family, etc.), the location of the session, and duration of the session in minutes.

See the California Code of Regulations (CCR) Title 9 1830.205 and 1830.210 for additional information.

Treatment Record Standards

General guidelines:

- All members' treatment records must contain:
 - a bio-psychosocial assessment,
 - documentation of the medical necessity criteria identified in this section, in the “Medical Necessity Criteria” section of this manual, and CCR Title 9 1830.205,
 - a treatment plan,
 - follow-up assessments,
 - focus of treatment, and
 - disposition/discharge plan.

Medical and psychological treatment documentation and progress notes must be current and treatment plans shall be updated or completed at least annually.

In addition to including the Medical Necessity Criteria described above, treatment records should reflect documentation as specified below.

1. Each page in the treatment record contains the member's name or ID number.
2. Each treatment record includes the member's address, employer or school name, home telephone number, work telephone number, emergency contacts, marital status or legal status, appropriate consent forms, and guardianship information if relevant.
3. All entries in the treatment record include the responsible clinician's name, professional degree, and relevant identification number, if applicable.
4. All entries in the treatment record are dated, and include the type, date, location and duration of the service.
5. The treatment record is legible to someone other than the writer. (A second reviewer examines any record judged to be illegible by one clinical reviewer).
6. Relevant medical conditions are listed, prominently identified, and revised as appropriate in the treatment record.
7. Presenting problems, along with relevant psychological and social conditions affecting the member's medical and psychiatric status, are documented in the treatment record.
8. Special status situations, such as imminent risk of harm, suicidal ideation, or elopement potential, are prominently noted, documented and revised in the treatment record in compliance with ValueOptions' written protocols.
9. Allergies, adverse reactions or no known allergies are clearly documented in the treatment record.
10. A medical and psychiatric history is documented in the treatment record, including previous treatment dates, provider identification, therapeutic interventions and responses, sources of clinical data, relevant family information, results of laboratory tests, and consultation reports.
11. For members 12 and older, documentation in the treatment record includes past and present use of cigarettes and alcohol, as well as illicit, prescribed, and over-the-counter drugs. N/A if the member is under the age of twelve.

12. A mental status evaluation that includes the member's affect, speech, mood, thought content, judgment, insight, attention, concentration, memory and impulse control is documented in the treatment record.
13. A DSM-IV/ICD9 diagnosis, consistent with the presenting problems, history, mental status examination, and/or other assessment data is documented in the treatment record.
14. Treatment plans are consistent with diagnoses and have both objective measurable goals and estimated time frames for goal attainment or problem resolution.
15. The focus of treatment interventions is consistent with the treatment plan goals and objectives, and with the medical necessity criteria for specialty mental health services.
16. Each treatment record indicates what medications have been prescribed, the dosages of each, and the dates of initial prescription or refills. For non-prescribing providers, each treatment record indicates what medications have been prescribed and the name of the prescriber. N/A is scored if medications are not prescribed.
17. Informed consent for medication and the member's level of understanding is documented. N/A if medication is not prescribed or the provider being reviewed is not a prescriber (e.g., MSW, PhD).
18. When medication is prescribed, there is evidence of consistency among the signs and symptoms, diagnosis, and medication prescribed. N/A is scored if medication is not prescribed or the provider being reviewed is not a prescriber (e.g. MSW, PhD).
19. Progress notes describe member strengths and limitations in achieving treatment plan goals and objectives.
20. Members who become homicidal, suicidal, or unable to conduct activities of daily living are promptly referred to the appropriate level of care.
21. The treatment record documents preventive services, as appropriate (e.g. relapse prevention, stress management, wellness programs, lifestyle changes, and referrals to community resources).
22. The treatment record documents dates of follow-up appointments or, as appropriate, a discharge plan.
23. There is evidence that the clinical assessment is culturally relevant (i.e. addresses issues relevant to the member's race, religion, ethnicity, age, gender, sexual orientation, level of education, socio-economic level, etc.).
24. There is evidence that the treatment plan is culturally relevant. (i.e., addresses issues relevant to the member's race, religion, ethnicity, age, gender, sexual orientation, level of education, socio-economic level, etc.).
25. There is evidence in the record of coordination of care with the PCP or declination of this coordination by the member.
26. The treatment record has evidence of continuity and coordination of care between behavioral healthcare institutions, ancillary providers and or consultants.
27. The treatment record reflects evidence of coordination of care with other outpatient behavioral health providers.
28. The record reflects evidence of coordination with the referral source if a referral was made.