

## **SECTION 1 – INTRODUCTION**

This Practice Guidelines Manual applies to all clients, regardless of payor source, and is expected to be the official documentation guide for medical record standards.

### **Standard Guidelines**

The practice guidelines for Amador County Behavioral Health (ACBH) for all services provided, including those that are submitted for reimbursement to any Federal, State, or private source shall be based on complete and timely documentation in the client's mental health record. Any services provided which do not meet standards and requirements shall not be submitted for reimbursement. All services provided are described in this Practice Guidelines Manual.

### **Timeliness of Documentation**

Documentation of all services is expected to be completed "during or as soon as practicable after it is provided in order to maintain an accurate medical record". This statement is from the Centers for Medicare and Medicaid Services (CMS) Internet Only Manual (IOM). CMS does not provide any specific period. **ACBH has set an expectation for documentation of services to be completed within 72 hours from the day of service.** In situations where timely recording of services is prevented, the service shall be entered as soon as possible. For documentation completed two weeks after the date of service, the services will not be submitted for reimbursement to any Federal, State, or private source. State and Federal industry standards indicate two weeks is a reasonable standard. **In all cases, the notes must still be documented for the medical record.** Charting time shall be included in the total time for the service. For example, a 50 minute session, with 10 minutes to complete the documentation will be billed as a total of 60 minutes.

### **Abbreviations**

Abbreviations should be consistent with list included in appendix. Other clients should not be identified by name in a client's chart.

### **Travel time**

Travel time may be billed when traveling from a provider site to an off-site location(s) where Medi-Cal specialty mental health services are delivered. Travel cannot be claimed for travel between provider sites or from a staff member's residence to a provider site. A provider site is defined as a site with a provider number. If applicable, travel time must be linked to the service provided. Travel time may not be claimed solely as a transportation service.

### **Signatures**

Signatures on all notes must include name and credential. All provider signatures must be dated. For electronic signatures, the electronic signature mechanisms used will be unique to the signer, under signer's sole control, capable of being verified and linked to the data so that, if the data is changed, the signature is invalidated.

### **Amending Records**

When a correction needs to be made in a documented service, the service can be edited or deleted, unless payment or claim has been entered against the service. Designated staff can either make a correction to one or more of the service entry fields, or delete the service entirely and correctly enter the appropriate service. Services that have payments or claims entered against them can only be corrected by ACBH's Fiscal staff. Services are usually claimed at the end of the month following the date of service and, therefore must be deleted within that time frame.

For electronic health records, the content of a progress note cannot be altered once it is final approved. In order to make an amendment to the content of a progress note, an addendum must be written within the note. The amended note will be dated the same as the note that needs amending and the signature date will be the date the note was amended.

For paper records, the procedure is to line out the information to be amended, clearly add the new information and initial and date the change on the record to be amended.

### **Cultural and Linguistic Services**

When applicable, information shall be provided in alternative formats. If a client is Limited English Proficient, there shall be documentation that interpreter services were offered and provided and an indication of the client's response. There shall be documented evidence that the client is made aware that specialty mental health services are available in the client's preferred language. Service-related personal correspondence shall be provided in the client's preferred language either by written or oral translation with assurance that the client understands the information provided. There shall be documentation of linking clients to culture-specific and/or linguistic services as necessary.

## **SECTION 2 – SPECIALITY MENTAL HEALTH SERVICES**

Any Specialty Mental Health services, Targeted Case Management, or Crisis services provided by staff other than the following, requires a co-signature by licensed or waived staff:

|      |                                    |
|------|------------------------------------|
| ASW  | Associate Clinical Social Worker   |
| LCSW | Licensed Clinical Social Worker    |
| MD   | Medical Doctor                     |
| MFT  | Marriage & Family Therapist        |
| MFTI | Marriage & Family Therapist Intern |
| RN   | Registered Nurse                   |
| LVN  | Licensed Vocational Nurse          |
| LPT  | Licensed Psychiatric Technician    |

### **Graduate Students**

A “Graduate Student” is an individual participating in a field intern/graduate student placement while enrolled in an accredited Masters in Social Work (MSW) or Masters of Art (MA)/Masters of Science (MS) or clinical/educational psychology doctorate degree program that will prepare the student for licensure within his/her professional field. Graduate Students may perform the following activities under the supervision of a licensed or waived professional within their scope of practice:

- Can conduct comprehensive assessments and client plans, but require a co-signature by licensed or waived staff
- Can write progress notes for individual and group therapy, but require a co-signature by licensed or waived staff
- Can claim for any service within the scope of practice, but require oversight and co-signature of licensed or waived staff

### **Definition of Mental Health Services**

“Mental Health Services” means those individual or group therapies and interventions that are designed to provide reduction of mental disability and improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral.

*Note: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14021.4 and 14684, Welfare and Institutions Code.*

### **Medical Necessity Criteria**

At minimum, clients must meet medical necessity criteria as described in California Code of Regulations, Title 9, in order to receive outpatient specialty mental health services.

- The client must have a qualifying mental health diagnosis that is the focus of treatment. See list for included and excluded diagnoses.
- As a result of the mental health diagnosis, **there must be a significant impairment in an area of life functioning.**
- There needs to be an indication that the client's functioning would show improvement with mental health intervention, which could not be provided solely through physical health care providers.

### **Included Diagnoses pursuant to CCR Title 9, Section § 1830.205**

The client must have one of the following diagnoses in the Diagnostic and Statistical Manual of Mental Disorders, DSM-E, Fifth Edition (2013) published by the American Psychiatric Association, along with the covered ICD-10 code. See *Attachment A* for the complete list of included diagnoses.

### **Excluded Diagnoses pursuant to CCR Title 9, Section § 1830.205**

- Mental Retardation
- Learning Disorders
- Motor Skills Disorders
- Communication Disorders
- Autistic Disorders
- Tic Disorders
- Delirium, Dementia and Amnesic and other Cognitive Disorders
- Mental Disorders due to a general medical condition
- Substance-Related Disorder
- Sexual Dysfunction
- Sleep Disorders
- Antisocial Personality Disorder

Clients may receive services for an included diagnosis when an excluded diagnosis also presents.

### **Client Treatment Plans**

Treatment Plans shall be used for Specialty Mental Health Services (SMHS). Treatment Plans are not required for Crisis services. Client Treatment Plans must be fully completed within 60 days of intake date and must be completed on all clients who receive services for 60 or more days. Prior to the client plan being approved, the following SMHS and service activities are reimbursable:

- Assessment

- Plan Development
- Crisis Intervention
- Crisis Stabilization
- Medication Support Services (for assessment, evaluation, or plan development; or if there is an urgent need, which must be documented)
- Targeted Case Management and Intensive Care Coordination (ICC) (for assessment, plan development, and referral/linkage to help a beneficiary obtain needed services including medical, alcohol and drug treatment, social, and educational services)

Treatment plans must be updated at least annually or when there are significant changes in the client's condition and must be signed and dated when completed by the person providing the service or a person representing the team or program providing the service.

Treatment plans must:

- Be specific, observable, and/or specific quantifiable goals/treatment objectives related to the client's mental health needs and functional impairments as a result of the mental health diagnosis. The objectives are short term steps that the client needs to take in order to accomplish the goal.
- Include the proposed type(s) of intervention/modality including a detailed description of the intervention to be provided. The interventions are the service activities that are designed to assist the client in order to meet their goals. The interventions must be consistent with the goal.
- Include the proposed frequency and duration of the intervention(s). (Ad Hoc does not meet the requirement for frequency and duration)
- Include interventions that focus and address the identified functional impairments as a result of the mental health diagnosis
- Include interventions that are consistent with client plan goal(s)/treatment objective(s)
- Be consistent with the qualifying diagnoses and the interventions of the progress notes.
- Include signatures of;
  - the person providing the service(s), or;
  - a person representing a team or program providing the service(s), or;

- a co-signer, if the client plan is used to establish that services are provided under the direction of an approved category of staff
- Include documentation of client's degree of participation and agreement with the plan as evidenced by:
  - Reference to the client's participation in and agreement in the body of the plan, or;
  - The client's signature on the plan, or;
  - A description of the client's participation and agreement in the progress notes
- Include the client's signature or the signature of the client's legal representative on the treatment plan when:
  - The client is expected to be a Long Term client, AND;
  - The treatment plan provides that the client will be receiving more than one type of Specialty Mental Health Service
  - If the client's signature or the signature of the client's representative is required on the client plan and the client refuses or is unavailable for signature, the treatment plan shall include a written explanation of the refusal or unavailability to sign. Every subsequent service must address the attempt to obtain client signature and be documented.
- Include documentation in the treatment plan that a copy of the treatment plan was offered to the client

### **Long Term Clients**

For the purpose of treatment planning and approval in Amador County, a long term client is defined as a client who meets medical necessity criteria, requires more than six months of Specialty Mental Health Services and cannot be stepped down to primary care due to the complexity of medication regimen, chronicity, increased likelihood of relapse and/or personality attributes which make referrals to primary care difficult.

**A. ASSESSMENT**

**CCR Title 9, Div.1 §1810.204**

“Assessment” means a service activity which may include a clinical analysis of the history and current status of a beneficiary’s mental, emotional, or behavioral disorder; relevant cultural issues and history; diagnosis; and the use of testing procedures.

*Note: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14021.4 and 14684, Welfare and Institutions Code.*

**Practice Guidelines**

- Amador County Behavioral Health requires that Assessments are completed as part of the Intake process. It is recognized that in the first visit the Assessment may not be fully completed.
- In order to reestablish medical necessity, the Assessment must be completed at least every two years.
- The following categories are able to provide Assessment services:
  - ACSW Associate Clinical Social Worker
  - LCSW Licensed Clinical Social Worker
  - MD Medical Doctor
  - MFT Marriage & Family Therapist
  - MFTI Marriage & Family Therapist Intern
  - Graduate Students

The following elements are required:

Date of service, provider name and signature and date, length in minutes, type of service, client name and client number.

**Presenting problem**

The client’s chief complaint, history of presenting problem(s), including current level of functioning, relevant family history and current family information.

**Relevant conditions and psychosocial factors affecting the client’s physical health and mental health**

Living situation, daily activities, social support, cultural and linguistic factors and history of trauma or exposure to trauma.

**A. ASSESSMENT - continued**

**CCR Title 9, Div.1 §1810.204**

Mental health history

Previous treatment, including providers therapeutic modality (e.g. medications psychosocial treatments) and response, and inpatient admissions. If possible, include information from other sources of clinical data, such as previous mental health records, and relevant psychological testing or consultation reports.

Medical history

Relevant physical health conditions reported by the beneficiary or a significant support person, include name and address of current source of medical treatment. For children and adolescents, the history must include prenatal and perinatal events and relevant/significant developmental history, such as smoking during pregnancy, alcohol during pregnancy, drugs or medication during pregnancy, and any complications. Milestones could be addressed such as motor skills, language, social/attachment, problems during infancy/early childhood. If possible, include other medical information from medical records or relevant consultation reports.

Medications

Information about medications the client has received, or is receiving, to treat mental health or medical conditions, including duration of medical treatment. The assessment shall include documentation of the absence or presence of allergies or adverse reactions to medications, and documentation of an informed consent for medications.

Substance exposure/substance use

Past and present use of tobacco, alcohol, caffeine, complementary and alternative medications, and over-the-counter drugs, and illicit drugs. Include type, amount, duration, related health/functional problems, frequency, pattern of use, last use

Client strengths

Documentation of the client's strengths in achieving client plan goals related to the client's mental health needs and functional impairments as a result of the mental health diagnosis

Risks

Situations that present a risk to the client and/or others, including past trauma

**A. ASSESSMENT – continued**

**CCR Title 9, Div.1 §1810.204**

Mental status examination

Appearance

Orientation

Alertness

Affect

Mood

Dress/Grooming

Eye Contact

Speech

Recent Memory

Remote Memory

Psychomotor Activity

Conceptual Disorganization

Thought Content

Perceptual Functioning

Attitude

Insight

Judgment

Attention/Concentration

Impulse Control

Complete DSM diagnosis

From the most current DSM, or a diagnosis from the most current ICD-code shall be documented consistent with the presenting problems, history, mental status examination and/or other clinical data.

**B. CRISIS INTERVENTION**

**CCR Title 9, Div.1 §1810.209**

“Crisis Intervention” means a service, lasting less than 24-hours, to or on behalf of a beneficiary for a condition which requires more timely response than a regularly scheduled visit. Service activities may include but are not limited to assessment, collateral and therapy.

Crisis Intervention is an immediate emergency response that is intended to help the client cope with a crisis (e.g., potential danger to self or others; potentially life altering event; severe reaction that is above the client’s normal baseline, etc.). Crisis Intervention services are responses where a regularly scheduled visit will not meet the urgent or emergency nature of an individual crisis.

Crisis Intervention activities may be face-to-face or by telephone with the client or significant support persons and may be provided in the office or in the community. Documentation must support that the crisis was an unplanned service.

Crisis Intervention is distinguished from crisis stabilization by being delivered by providers who are not eligible to deliver crisis stabilization or who are eligible, but deliver the service at a site other than a provider site that has been certified by the department or a Mental Health Plan to provide crisis stabilization.

Crisis Intervention is not reimbursable on days when Crisis Residential Treatment Services, Psychiatric Health Facility Services, Psychiatric Nursing Facility Services, or Psychiatric Inpatient Hospital Services are reimbursed, except for the day of admission to those services.

The maximum amount claimable for Crisis Intervention in a 24-hour period is 8 hours.

Crisis Intervention billing should include time spent providing the crisis service, travel (if provided in the field) and documentation.

*Note: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14021.4 and 14684, Welfare and Institutions Code.*

**B. CRISIS INTERVENTION – Continued**

**CCR Title 9, Div.1 §1810.209**

**Documentation Standards**

- The following categories are able to provide Crisis Intervention Services:
  - ASW - Waivered
  - LCSW – Licensed
  - MD - Licensed
  - MFT - Licensed
  - MFT-Intern – Waivered
  - RN, LVN, LPT – Registered/Licensed
  - Graduate Students under the supervision of a licensed or waived professional – **Co-signature Required**
  - Rehabilitation Specialist, Adjunct Mental Health Staff and other staff not meeting above categories - under the supervision of a licensed or waived professional – **Co-signature Required. Any diagnosis must be provided by the licensed or waived professional. Assessment and/or therapy may not be included in the service.**

Documentation must describe a clear description of the crisis, in order to distinguish the situation from a more routine event and the interventions used to help stabilize the client. Items that shall be contained in the client record related to the crisis intervention include:

1. Client name and client number;
2. Timely documentation of relevant aspects of client care, including documentation of medical necessity;
3. Documentation of client encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions;
4. Interventions applied, client’s response to the interventions and location of the interventions;
5. Date services were provided;
6. Documentation of referrals to community resources and other agencies, when appropriate;
7. Documentation of the plan for follow-up care, or as appropriate, a discharge summary; and
8. The amount of time taken to provide the services; and
9. The signature of the person providing the service (or electronic equivalent); the person’s type of professional degree, licensure, or job title and co-signature, if appropriate.

**C. COLLATERAL**

**CCR Title 9, Div.1 §1810.206**

“Collateral” means a service activity to a significant support person in a beneficiary’s life with the intent of improving or maintaining the mental health status of the beneficiary. The purpose of this service is to help meet the needs of the beneficiary in terms of achieving the goals of the beneficiary’s client plan. The beneficiary may or may not be present for this service activity. **(This does not include staff to staff discussions, which could be Plan Development, Assessment or Targeted Case Management)**

*Note: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14021.4 and 14684, Welfare and Institutions Code.*

**Documentation Standards**

- The following categories are able to provide Collateral services:
  - ASW - Waivered
  - LCSW – Licensed
  - MD - Licensed
  - MFT - Licensed
  - MFT-Intern – Waivered
  - RN, LVN, LPT – Registered/Licensed
  - Graduate Students under the supervision of a licensed or waived professional – **Co-signature Required**
  - Rehabilitation Specialist, Adjunct Mental Health Staff and other staff not meeting above categories - under the supervision of a licensed or waived professional – **Co-signature Required. Any diagnosis must be provided by the licensed or waived professional.**

Documentation must describe how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning outline in the treatment plan. Items that shall be contained in the client record related to the client’s progress in treatment include:

1. Client name and client number;
2. Timely documentation of relevant aspects of client care, including documentation of medical necessity;
3. Documentation of client encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions;

4. Interventions applied (consistent with treatment plan goals), client's response to the interventions and location of the interventions;
5. Date services were provided;

**C. COLLATERAL - continued**

**CCR Title 9, Div.1 §1810.206**

6. Documentation of referrals to community resources and other agencies, when appropriate;
7. Documentation of the plan for follow-up care, or as appropriate, a discharge summary; and
8. The amount of time taken to provide the services; and
9. The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, licensure, or job title or co-signature, if appropriate.

**D. THERAPY – Individual or Group CCR Title 9, Div.1 §1810.250**

“Therapy” means a service activity that is a therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments. Therapy may be delivered to an individual or group of beneficiaries and may include family therapy at which the beneficiary is present. Each beneficiary for which a family therapy claim will be submitted must be present at the therapy session.

*Note: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14021.4 and 14684, Welfare and Institutions Code.*

**Documentation Standards**

- The following categories are able to provide Therapy services:
  - ASW - Waivered
  - LCSW – Licensed
  - MFT - Licensed
  - MFT-Intern – Waivered
  - Graduate Students

Documentation must describe how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning outline in the treatment plan. Progress notes for Family Therapy must clearly document how the session focused primarily on reducing each beneficiary’s symptoms. Items that shall be contained in the client record related to the client’s progress in treatment include:

1. Client name and client number;
2. Timely documentation of relevant aspects of client care, including documentation of medical necessity;
3. Documentation of client encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions;
4. Interventions applied (consistent with treatment plan goals), client’s response to the interventions and location of the interventions;
5. Date services were provided;
6. Documentation of referrals to community resources and other agencies, when appropriate;
7. Documentation of the plan for follow-up care, or as appropriate, a discharge summary; and
8. The amount of time taken to provide the services; and

9. The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, licensure, or job title and a co-signature, if appropriate.

**E. REHABILITATION – Individual or Group or IHBS**  
**CCR Title 9, Div.1 §1810.243**

“Rehabilitation” means a service activity which includes, but is not limited to assistance in improving, maintaining, or restoring a beneficiary's or group of beneficiaries' functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources; and/or medication education.

*NOTE: Authority: Section 14680, Welfare and Institutions Code.*

*Reference: Sections 5777, 14021.4, and 14684, Welfare and Institutions Code.*

“Intensive Home Based Services” (IHBS) are mental health rehabilitation services provided to all EPSDT beneficiaries who are determined to need this level of service. IHBS are individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child/youth's functioning and are aimed at helping the child/youth build skills necessary for successful functioning in the home and community and improving the child/youth's family ability to help the child/youth successfully function in the home and community.

**Documentation Standards**

- The following categories are able to provide Rehabilitation Services:
  - ASW - Waivered
  - LCSW – Licensed
  - MD - Licensed
  - MFT - Licensed
  - MFT-Intern – Waivered
  - RN, LVN, LPT – Registered/Licensed
  - Graduate Students under the supervision of a licensed or waived professional – **Co-signature Required**
  - Rehabilitation Specialist, Adjunct Mental Health Staff and other staff not meeting above categories - under the supervision of a licensed or waived professional – **Co-signature Required. Any diagnosis must be provided by the licensed or waived professional.**

**E. REHABILITATION – Individual or Group or IHBS - continued**  
**CCR Title 9, Div.1 §1810.243**

Documentation must describe how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning outline in the treatment plan. Items that shall be contained in the client record related to the client's progress in treatment include:

1. Client name and client number;
2. Timely documentation of relevant aspects of client care, including documentation of medical necessity;
3. Documentation of client encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions;
4. Interventions applied (consistent with treatment plan goals), client's response to the interventions and location of the interventions;
5. Date services were provided;
6. Documentation of referrals to community resources and other agencies, when appropriate;
7. Documentation of the plan for follow-up care, or as appropriate, a discharge summary; and
8. The amount of time taken to provide the services; and
9. The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, licensure, or job title and co-signature, if appropriate.

**F. PLAN DEVELOPMENT**

**CCR Title 9, Div.1 §1810.232**

“Plan Development” means a service activity which consists of development of client plans, approval of client plans, and/or monitoring of a beneficiary’s progress.

*Note: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14021.4 and 14684, Welfare and Institutions Code.*

**Documentation Standards**

- The following categories are able to provide Plan Development Services:
  - ASW - Waivered
  - LCSW – Licensed
  - MD - Licensed
  - MFT - Licensed
  - MFT-Intern – Waivered
  - RN, LVN, LPT – Registered/Licensed
  - Graduate Students under the supervision of a licensed or waived professional – **Co-signature Required**
  - Rehabilitation Specialist, Adjunct Mental Health Staff and other staff not meeting above categories - under the supervision of a licensed or waived professional – **Co-signature Required. Any diagnosis must be provided by the licensed or waived professional.**

Documentation must describe how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning outline in the treatment plan. Items that shall be contained in the client record related to the client’s progress in treatment include:

1. Client name and client number;
2. Timely documentation of relevant aspects of client care, including documentation of medical necessity;
3. Documentation of client encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions;
4. Interventions applied (consistent with treatment plan goals), client’s response to the interventions and location of the interventions;
5. Date services were provided;

6. Documentation of referrals to community resources and other agencies, when appropriate;
7. Documentation of the plan for follow-up care, or as appropriate, a discharge summary; and

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| <b>F. PLAN DEVELOPMENT - continued</b> | <b>CCR Title 9, Div.1 §1810.232</b> |
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8. The amount of time taken to provide the services; and
9. The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, licensure, or job title and co-signature, if appropriate.

**G. TARGETED CASE MANAGEMENT and ICC**

**CCR Title 9, Div.1 §1810.249**

“Targeted Case Management” means services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community service. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary’s progress; placement services; and plan development.

Targeted Case Management Services are not reimbursable on days when the following services are reimbursed, except for day of admission or for placement services as provided in subsection: Psychiatric Inpatient Hospital Services, Psychiatric Health Facility Services, Psychiatric Nursing Facility Services.

Targeted Case Management Services solely for the purpose of coordinating placement of the beneficiary on discharge from the psychiatric inpatient hospital, psychiatric health facility or psychiatric nursing facility may be provided during the 30 calendar days immediately prior to the day of discharge, for a maximum of three nonconsecutive periods of 30 calendar days or less per continuous stay in the facility.

*Note: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14021.4 and 14684, Welfare and Institutions Code.*

Intensive Care Coordination (ICC) is a targeted case management service that facilitates assessment of, care planning for and coordination of services, including urgent services for all EPSDT beneficiaries who are determined to need this level of service.

**Documentation Standards**

- The following categories are able to provide Targeted Case Management services:
  - ASW - Waivered
  - LCSW – Licensed
  - MD - Licensed
  - MFT - Licensed
  - MFT-Intern – Waivered

- RN, LVN, LPT – Registered/Licensed
- Graduate Students under the supervision of a licensed or waived professional – **Co-signature Required**

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| <p><b>G. TARGETED CASE MANAGEMENT and ICC – continued</b><br/><b>CCR Title 9, Div.1 §1810.249</b></p> |
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- Rehabilitation Specialist, Adjunct Mental Health Staff and other staff not meeting above categories - under the supervision of a licensed or waived professional – **Co-signature Required. Any diagnosis must be provided by the licensed or waived professional.**

Documentation must describe how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning outline in the treatment plan. Items that shall be contained in the client record related to the client’s progress in treatment include:

1. Client name and client number;
2. Timely documentation of relevant aspects of client care, including documentation of medical necessity;
3. Documentation of client encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions;
4. Interventions applied (consistent with treatment plan goals), client’s response to the interventions and location of the interventions;
5. Date services were provided;
6. Documentation of referrals to community resources and other agencies, when appropriate;
7. Documentation of the plan for follow-up care, or as appropriate, a discharge summary; and
8. The amount of time taken to provide the services; and
9. The signature of the person providing the service (or electronic equivalent); the person’s type of professional degree, licensure, or job title and co-signature, if appropriate.

## **H. MEDICATION SUPPORT**

**CCR Title 9, Div.1 §1810.225**

“Medication Support” means services that include prescribing, administering, dispensing, and monitoring of psychiatric medications or biologicals which are necessary to alleviate the symptoms of mental illness. May include evaluation of the need for medication, evaluation of clinical effectiveness and side effects, obtaining informed consent, instruction in the use, risks and benefits of and alternatives for medication; and collateral and plan development related to the delivery of the service and/or assessment of the consumer.

Medication support services can include Medication Evaluation, Medication Management, Medication Refill or Medication Injection. These services can be provided with individual clients, significant support persons of the client, or with groups of clients. Though medication support services are generally with the client, if the appropriate staff member (see below) has to complete required paperwork regarding the client's treatment, and it requires the expertise of a medication support staff to understand, analyze, and write about, a medication support service can be billed, if documented clearly as such.

Written medication consents, signed by the client agreeing to the administration of psychiatric medication shall be obtained. The medication consent shall include, but not be limited to, the reasons for taking such medications; reasonable alternative treatments if available, if any; the type, range of frequency and amount, method (oral or injections), and duration of taking the medication; probable side effects; possible additional side effects which may occur to clients taking such medications beyond three (3) months; and that the consent, once given, may be withdrawn at any time by the client.

Maximum amount claimable for Medication Support Services in a 24 hour period is 4 hours per client.

### **Documentation Standards**

- The following categories are able to provide Medication Support Services:
  - MD - Licensed
  - RN, LVN, LPT – Registered/Licensed

**H. MEDICATION SUPPORT - continued CCR Title 9, Div.1 §1810.225**

Documentation must describe how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning outline in the treatment plan. Items that shall be contained in the client record related to the client's progress in treatment include:

1. Client name and client number;
2. Timely documentation of relevant aspects of client care, including documentation of medical necessity;
3. Documentation of client encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions;
4. Interventions applied (consistent with treatment plan goals), client's response to the interventions and location of the interventions;
5. Date services were provided;
6. Documentation of referrals to community resources and other agencies, when appropriate;
7. Documentation of the plan for follow-up care, or as appropriate, a discharge summary; and
8. The amount of time taken to provide the services; and
9. The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, licensure, or job title.

## **I. REASONS FOR RECOUPMENT**

### **Crisis Intervention:**

Crisis Intervention is not reimbursable on days when Crisis Residential Treatment Services, Psychiatric Health Facility Services, Psychiatric Nursing Facility Services, or Psychiatric Inpatient Hospital Services are reimbursed, except for the day of admission to those services. The maximum amount claimable for Crisis Intervention in a 24-hour period is 8 hours. CCR, Title 9, Chapter 11, Section 1840.366(b)

### **Medication Support Services:**

Time claimed beyond the maximum amount of 4 hours in a 24-hour period. CCR, Title 9, Chapter 11, Section 1840.372

### **Targeted Case Management:**

Targeted Case Management Services are not reimbursable on days when the following services are reimbursed, except for day of admission or for placement services: Psychiatric Inpatient Hospital Services, Psychiatric Health Facility Services, Psychiatric Nursing Facility Services. *(Targeted Case Management Services solely for the purpose of coordinating placement of the beneficiary on discharge from the psychiatric inpatient hospital, psychiatric health facility or psychiatric nursing facility may be provided during the 30 calendar days immediately prior to the day of discharge, for a maximum of three nonconsecutive periods of 30 calendar days or less per continuous stay in the facility. CCR, Title 9, Chapter 11, Section 1840.374)*

### **Day Rehabilitation and Day Treatment Intensive:**

Day Rehabilitation and Day Treatment Intensive are not reimbursable under the following circumstances:

- When Crisis Residential Treatment Services, Psychiatric Inpatient Hospital Services, Psychiatric Health Facility Services, or Psychiatric Nursing Facility Services are reimbursed, except for the day of admission to those services.
- When provided by Day Rehabilitation or Day Treatment Intensive staff during the same time period that Day Rehabilitation or Day Treatment Intensive is provided.
- Two full-day or one full-day and one half-day or two half-day programs may not be provided to the same beneficiary on the same day. CCR, Title 9, Chapter 11, Section 1840.360

## **I. REASONS FOR RECOUPMENT – continued**

### **Jail:**

Mental Health Services may not be billed to Medi-Cal for services provided to beneficiaries in jail.

### **Juvenile Hall – Allows for Case Management Services only:**

Mental Health services may not be billed to Medi-Cal for youth in juvenile hall UNLESS the youth are adjudicated and are awaiting placement. (Adjudicated delinquent is a youth who has been found by a judge in juvenile court to have committed a violation of the criminal law. The judge can formally adjudicate the youth as an initial step before imposing a sentence or punishment.)

### **IMD - Allows for Case Management Services only:**

Institutions for Mental Disease (IMDs) are inpatient facilities of more than 16 beds whose patient roster is more than 51% people with severe mental illness. Federal Medicaid matching payments are prohibited for IMDs with a population between the ages of 22 and 64. IMDs for persons under age 22 or over age 64 are permitted, at state option, to draw federal Medicaid matching funds. Case Management Services may only be provided if the beneficiary is 65 or older, or if the beneficiary is under 21 and is a patient in a hospital or another accredited facility.

### **Medical Necessity**

Documentation in the medical record does not establish that the beneficiary has a diagnosis contained in included diagnosis list.

Documentation does not establish that, as a result of a mental disorder, the client has at least one of the following impairments:

- Significant impairment in an important area of life functioning
- Probability of significant deterioration in an important area of life functioning
- For children, the probability the child will not progress developmentally as individually appropriate
- For those under 21, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate

Documentation in the medical record does not establish that the focus of the proposed intervention is to address the condition identified (diagnosis).

## **I. REASONS FOR RECOUPMENT – continued**

Documentation in the medical record does not establish the expectation that the proposed intervention will do, at least, one of the following:

- Significantly diminish the impairment
- Prevent significant deterioration in an important area of life functioning
- For those under 21, allow the child to progress developmentally as individually appropriate

### **Treatment Plan**

Initial treatment plan not completed within the time period specified within 60 days of the intake, unless there is documentation supporting the need for more time.

The treatment plan is not completed, at least on an annual basis.

No documentation of the client or legal guardian's participation in the plan or written explanation of the client's refusal or unavailability to sign.

### **Progress Notes**

No progress note for the service claimed.

The time claimed is greater than the time documented.

The progress note indicates that the service provided was solely for one of the following:

- Academic educational service
- Vocational service that has work or work training as its actual purpose
- Recreation
- Socialization that consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors

The claim for a group activity was not properly apportioned to all clients present.

The progress note was not signed (or electronic equivalent) by the person(s) providing the service.

The progress note indicates the service provided was solely clerical.

The progress note indicates the service provided was solely payee related.

No service was provided.

**I. REASONS FOR RECOUPMENT – continued**

The service was claimed for a provider on the Office of Inspector General's list of Excluded Individuals and Entities.

The service was claimed for a provider on the Medi-Cal Suspended and Ineligible Provider List.

The service was not provided within the scope of practice of the person delivering the service.

**SECTION 3 - INDIRECT SERVICES**

Indirect Services are service activities that are not reimbursable as a Specialty Mental Health Service. Indirect Services do not require a progress note, but if a service is provided to a client that should be documented, an informational note should be used. All Indirect Services shall be coded by using the current Keying Guide with appropriate time(s) included. All Indirect Services shall be keyed into the electronic system within 30 days of the indirect service. Below is a chart that differentiates indirect services from direct services. Please refer to the current Keying Guide for service codes and descriptions.

| <b>If the service activity is provided solely as the following, it is NON-REIMBURSABLE:</b>  | <b>How to code as non-reimbursable:</b>  | <b>Becomes reimbursable if:</b><br>*Documentation must include purpose, intervention, response and plan.   |
|--|--|--|
| Academic Educational Service<br>Vocational service that has work training as its actual purpose<br>Recreation<br>Socialization that consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors | General Time or Transportation accompanied by an informational note, as appropriate. | <b>N/A</b>   |
| Transportation<br>Travel time when no face-to-face contact with the client or significant support person was provided, including leaving a note or a message for the client  | General Time   | <b>N/A. Note:</b> Travel time is included in the total time documented to provide the direct service. Travel time must be from provider site to an off-site non-provider location. For example, cannot be claimed from a staff member’s residence to a provider site. <b>Cannot claim for travel from provider</b> |

|  |   | <b>site to provider site.</b>  |
|--|---|--|
| <b>If the service activity is provided solely as the following, it is NON-REIMBURSABLE:</b>  | <b>How to code as non-reimbursable:</b>                             | <b>Becomes reimbursable if:</b><br>*Documentation must include purpose, intervention, response and plan.   |
| Translation/interpretation   | General Time  | <b>N/A</b>   |
| Missed appointments, including documenting in the chart that a client missed an appointment  | Cancelled by client or staff or no show                             | Only if a direct service is provided such as a follow-up telephone contact with the client that includes required supporting documentation.  |
| Closing a case   | QIC/UR  |  |
| Leaving and/or listening to telephone messages   | General Time  | <b>N/A</b>   |
| Completing mandatory or court ordered reports, CPS, APS, Tarasoff, etc.  |   |  |
| Completing Social Security reports, if there is no face-to-face contact with the client or significant support person                    |   |  |
| Clerical tasks: faxing, copying, mailing, etc.   | General Time or QIC/UR if applicable (see UR/QI list of activities) | <b>N/A</b>   |
| Supervision in which the primary purpose is for the benefit of the clinician, even if the client's care is discussed.                    | Clinical Supervision  | Non-scheduled supervision meetings may be reimbursable if the <b>primary</b> purpose is for the client <b>AND</b> the progress note indicates intervention or action taken is consistent with the treatment plan goals, and indicates a result of the intervention and a plan. |
| Staff development activities, including conferences, workshops, trainings, reading literature, preparation or collecting materials for a | Training, Program Planning, or QIC/UR if applicable                 | <b>N/A</b>   |

|               |  |  |
|---------------|--|--|
| group session |  |  |
|---------------|--|--|

**SECTION 4 - UTILIZATION REVIEW AND QUALITY IMPROVEMENT ACTIVITIES**

Amador County Behavioral Health Department collects information regarding the staff time and other expenditures related to Utilization Review and Quality Improvement activities. These are activities performed by all licensed, non-licensed and other staff that are not directly billable to the client.

| <b>Utilization Review/QI Activities</b>  | <b>Examples</b>   |
|--|---|
| Utilization review and training activities related to monitoring of program integrity standards  | Chart reviews, compliance training  |
| Utilization review and training activities required as part of performance improvement projects  | Meetings, training, webinars, conference calls, minutes, report gathering and analyzing that are a result of the PIP teams.   |
| Quality Improvement Committee meetings, preparation time, documentation of minutes, and follow-up of clinical issues                                 | Meetings, minute taking, report gathering and analyzing, tracking and reporting any measures on the QI Work Plan  |
| Clerical time spent supporting utilization review chart selection, gathering of chart and billing documentation, and follow-up of clinical QI issues | Pulling charts for UR, entering or collecting data from chart reviews, support staff time in UR meetings and logging of UR data   |
| QI activities required for development, implementation, evaluation and revision of clinical practice guidelines                                      | Review of crisis utilization, monthly UR meetings, review of intakes, participation in Cultural Competence activities, including meetings, research, training and development of policies, Team and MDT meetings if not billed directly to the client |
| Participation and preparation for licensing program compliance, site reviews and/or audits   | Pre-audit chart reviews, policy and procedure review  |
| Utilization review activities required as part of medication monitoring  | Data collection, review of charts, preparation, reporting outcomes, discussion of improvements and recommendations  |

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|  |   |
|--|---|
| Training   | Time spent in training activities that are focused on improvement of access, capacity, client/family satisfaction, service delivery, clinical outcomes, continuity and coordination of care |
| Personnel time required for the operation of management information systems that are necessary for completion of utilization review activities | Data entry time for producing caseload reports, intake reports, demographic reports   |
| Plan development activities if not billed as case management or other specialty mental health service  | Review of treatment plans, review of progress notes, monitoring client's progress, if not billed directly to client   |

Attachment A

| Diagnosis Code | Description  | Diagnosis Code | Description  |
|----------------|--|----------------|--|
| F20.0          | Paranoid schizophrenia   |                |  |
| F20.1          | Disorganized schizophrenia   | F31.13         | Bipolar disord, crnt epsd manic w/o psych features, severe     |
| F20.2          | Catatonic schizophrenia  |                |  |
| F20.3          | Undifferentiated schizophrenia   | F31.2          | Bipolar disorder, crnt episode manic severe w psych features   |
| F20.5          | Residual schizophrenia   |                |  |
| F20.81         | Schizophreniform disorder  | F31.30         | Bipolar disorder, crnt epsd depress, mild or mod severt, unsp  |
| F20.89         | Other Schizophrenia  |                |  |
| F20.9          | Schizophrenia, unspecified   | F31.31         | Bipolar disorder, current episode depressed, mild              |
| F21            | Schizotypal disorder   |                |  |
| F22            | Delusional disorders   | F31.32         | Bipolar disorder, current episode depressed, moderate          |
| F23            | Brief psychotic disorder   |                |  |
| F24            | Shared psychotic disorder  | F31.4          | Bipolar disorder, crnt epsd depress, sev, w/o psych features   |
| F25.0          | Schizoaffective disorder, bipolar type   |                |  |
| F25.1          | Schizoaffective disorder, depressive type  | F31.5          | Bipolar disorder, crnt epsd depress, severe, w psych features  |
| F25.8          | Other schizoaffective disorders  |                |  |
| F25.9          | Schizoaffective disorder, unspecified  | F31.60         | Bipolar disorder, current episode mixed, unspecified           |
| F28            | Oth psych disorder not due to a sub or known physiol cond                        | F31.61         | Bipolar disorder, current episode mixed, mild                  |
| F29            | Unsp psychosis not due to a substance or known physiol cond                      | F31.62         | Bipolar disorder, current episode mixed, moderate              |
| F30.10         | Manic episode without psychotic symptoms, unspecified                            | F31.63         | Bipolar disorder, crnt epsd mixed, severe, w/o psych features  |
| F30.11         | Manic episode without psychotic symptoms, mild                                   | F31.64         | Bipolar disorder, crnt episode mixed, severe, w psych features |
| F30.12         | Manic episode without psychotic symptoms, moderate                               | F31.70         | Bipolar disorder, currently in remis, most recent episode unsp |
| F30.13         | Manic episode, severe, without psychotic symptoms                                | F31.71         | Bipolar disorder, in partial remis, most recent epsd hypomanic |
| F30.2          | Manic episode, severe with psychotic symptoms                                    | F31.72         | Bipolar disorder, in full remis, most recent episode hypomanic |
| F30.3          | Manic episode in partial remission   | F31.73         | Bipolar disorder, in partial remis, most recent episode manic  |
| F30.4          | Manic episode in full remission  |                |  |
| F30.8          | Other manic episodes   | F31.74         | Bipolar disorder, in full remis, most recent episode manic     |
| F30.9          | Manic episode, unspecified   |                |  |
| F31.0          | Bipolar I Disorder, Single Manic Episode without Psychotic Features, Unspecified | F31.75         | Bipolar disorder, in partial remis, most recent epsd depress   |
| F31.10         | Bipolar disorder, crnt episode manic w/o psych features, unsp                    | F31.76         | Bipolar disorder, in full remis, most recent episode depress   |
| F31.11         | Bipolar disorder, crnt episode manic w/o psych features, mild                    | F31.77         | Bipolar disorder, in partial remis, most recent episode mixed  |
| F31.12         | Bipolar disorder, crnt episode manic w/o psych features, mod                     | F31.78         | Bipolar disorder, in full remis, most recent episode mixed     |

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| Diagnosis Code | Description  | Diagnosis Code | Description                                 |
|----------------|--|----------------|---|
| F31.81         | Bipolar II disorder  | F39            | Unspecified Mood Disorder                   |
| F31.89         | Other bipolar disorder   | F40.00         | Agoraphobia, unspecified                    |
| F31.9          | Bipolar disorder, unspecified                                    | F40.01         | Agoraphobia with panic disorder             |
| F32.0          | Major depressive disorder, single episode, mild                  | F40.02         | Agoraphobia without panic disorder          |
| F32.1          | Major depressive disorder, single episode, moderate              | F40.10         | Social phobia, unspecified                  |
| F32.2          | Major depressv disord, single epsd, sev w/ psych features        | F40.11         | Social phobia, generalized                  |
| F32.3          | Major depressv disord, single epsd, severe with psych features   | F40.210        | Arachnophobia                               |
| F32.4          | Major depressv disorder, single episode, in partial remis        | F40.218        | Other animal type phobia                    |
| F32.5          | Major depressive disorder, single episode, in full remission     | F40.220        | Fear of thunderstorms                       |
| F32.89         | Other Specified Depressive Episodes                              | F40.228        | Other natural environment type phobia       |
| F32.9          | Major depressive disorder, single episode, unspecified           | F40.230        | Fear of blood                               |
| F33.0          | Major depressive disorder, recurrent, mild                       | F40.231        | Fear of injections and transfusions         |
| F33.1          | Major depressive disorder, recurrent, moderate                   | F40.232        | Fear of other medical care                  |
| F33.2          | Major depressv disorder, recurrent severe without psych features | F40.233        | Fear of injury                              |
| F33.3          | Major depressv disorder, recurrent, severe with psych symptoms   | F40.240        | Claustrophobia                              |
| F33.40         | Major depressive disorder, recurrent, in remission, unsp         | F40.241        | Acrophobia                                  |
| F33.41         | Major depressive disorder, recurrent, in partial remission       | F40.242        | Fear of bridges                             |
| F33.42         | Major depressive disorder, recurrent, in full remission          | F40.243        | Fear of flying                              |
| F33.8          | Other recurrent depressive disorders                             | F40.248        | Other situational type phobia               |
| F33.9          | Major depressive disorder, recurrent, unspecified                | F40.290        | Androphobia                                 |
| F34.0          | Cyclothymic disorder   | F40.291        | Gynephobia                                  |
| F34.1          | Dysthymic disorder   | F40.298        | Other specified phobia                      |
| F34.81         | Disruptive Mood Dysregulation Disorder                           | F40.8          | Other phobic anxiety disorders              |
| F34.89         | Other Specified Persistent Mood Disorder                         | F41.0          | Panic disorder without agoraphobia          |
| F34.9          | Persistent mood [affective] disorder, unspecified                | F41.1          | Generalized anxiety disorder                |
| F39            | Unspecified mood [affective] disorder                            | F41.3          | Other mixed anxiety disorders               |
|                |  | F41.8          | Other specified anxiety disorders           |
|                |  | F41.9          | Anxiety disorder, unspecified               |
|                |  | F42.2          | Mixed Obsessional Thoughts and Acts         |
|                |  | F42.3          | Hoarding Disorder                           |
|                |  | F42.4          | Excoriation Disorder                        |
|                |  | F42.8          | Other Obsessive-Compulsive Disorder         |
|                |  | F42.9          | Obsessive-compulsive Disorder, Unspecified  |
|                |  | F43.0          | Acute stress reaction                       |
|                |  | F43.10         | Post-traumatic stress disorder, unspecified |
|                |  | F43.11         | Post-traumatic stress disorder, acute       |
|                |  | F43.12         | Post-traumatic stress disorder, chronic     |
|                |  | F43.20         | Adjustment disorder, unspecified            |
|                |  | F43.21         | Adjustment disorder with depressed mood     |
|                |  | F43.22         | Adjustment disorder with anxiety            |

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| Diagnosis Code | Description   | Diagnosis Code | Description   |
|----------------|---|----------------|---|
| F43.23         | Adjustment disorder w/ mixed anxiety and depressed mood     | F60.6          | Avoidant personality disorder   |
|                |   | F60.7          | Dependent personality disorder  |
| F43.24         | Adjustment disorder with disturbance of conduct             | F60.81         | Narcissistic personality disorder   |
|                |   | F60.9          | Personality disorder, unspecified   |
| F43.25         | Adjustment disorder w mixed disturb of emotions and conduct | F63.0          | Pathological gambling   |
|                |   | F63.1          | Pyromania   |
| F43.29         | Adjustment Disorder with Other Symptoms                     | F63.2          | Kleptomania   |
| F44.0          | Dissociative amnesia  | F63.3          | Trichotillomania  |
| F44.1          | Dissociative fugue  | F63.81         | Intermittent explosive disorder   |
| F44.4          | Conversion disorder with motor symptom or deficit           | F63.9          | Impulse disorder, unspecified   |
|                |   | F64.1          | Dual Role Transvestism  |
| F44.5          | Conversion disorder with seizures or convulsions            | F64.2          | Gender identity disorder of childhood   |
|                |   | F64.9          | Gender identity disorder, unspecified   |
| F44.6          | Conversion disorder with sensory symptom or deficit         | F65.0          | Fetishism   |
|                |   | F65.1          | Transvestic fetishism   |
| F44.7          | Conversion disorder with mixed symptom presentation         | F65.2          | Exhibitionism   |
|                |   | F65.3          | Voyeurism   |
| F44.81         | Dissociative identity disorder                              | F65.4          | Pedophilia  |
| F44.9          | Dissociative and conversion disorder, unspecified           | F65.50         | Sadomasochism, unspecified  |
|                |   | F65.51         | Sexual masochism  |
| F45.0          | Somatization disorder                                       | F65.52         | Sexual sadism   |
| F45.1          | Undifferentiated somatoform disorder                        | F65.81         | Frotteurism   |
| F45.22         | Body dysmorphic disorder                                    | F65.9          | Paraphilia, unspecified   |
| F45.41         | Pain disorder exclusively related to psychological factors  | F68.10         | Factitious disorder, unspecified  |
| F45.42         | Pain disorder with related psychological factors            | F68.11         | Factitious disorder with predominantly psychological signs and symptoms         |
| F45.8          | Other somatoform disorders                                  | F68.12         | Factitious disorder with predominantly physical signs and symptoms              |
| F45.8          | Other somatoform disorders                                  |                |   |
| F48.1          | Depersonalization-derealization syndrome                    | F68.13         | Factitious disorder with combined psychological and physical signs and symptoms |
| F50.00         | Anorexia nervosa, unspecified                               | F80.82         | Social (Pragmatic) Communication Disorder                                       |
| F50.01         | Anorexia nervosa, restricting type                          | F80.9          | Developmental Disorder of Speech and Language, Unspecified                      |
| F50.02         | Anorexia nervosa, binge eating/purging type                 | F84.2          | Rett's syndrome   |
| F50.2          | Bulimia nervosa   | F84.3          | Other childhood disintegrative disorder   |
| F50.81         | Binge Eating Disorder                                       | F84.5          | Asperger's syndrome   |
| F50.89         | Other Specified Eating Disorder                             | F84.8          | Other pervasive developmental disorders   |
| F50.9          | Eating disorder, unspecified                                | F84.9          | Pervasive developmental disorder, unspecified                                   |
| F60.0          | Paranoid personality disorder                               | F90.0          | Attention-deficit/hyperactivity disorder, predominantly inattentive type        |
| F60.1          | Schizoid personality disorder                               |                |   |
| F60.3          | Borderline personality disorder                             |                |   |
| F60.4          | Histrionic personality disorder                             |                |   |
| F60.5          | Obsessive-compulsive personality disorder                   |                |   |

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| <b>Diagnosis Code</b> | <b>Description</b>   |       |   |
|-----------------------|--|-------|---|
|                       |  | F91.1 | Conduct disorder, childhood-onset type    |
|                       |  | F91.2 | Conduct disorder, adolescent-onset type   |
|                       |  | F91.3 | Oppositional defiant disorder             |
| F90.1                 | Attention-deficit/hyperactivity disorder, Predominantly Hyperactive Type | F91.8 | Other Conduct Disorder                    |
|                       |  | F91.9 | Conduct disorder, unspecified             |
| F90.2                 | Attention-deficit/hyperactivity disorder, combined type                  | F93.0 | Separation anxiety disorder of childhood  |
|                       |  | F93.8 | Other childhood emotional disorders       |
| F90.8                 | Attention Deficit/Hyperactivity Disorder, Other Type                     | F93.9 | Childhood emotional disorder, unspecified |
|                       |  | F94.0 | Selective mutism                          |
| F90.9                 | Attention-deficit/hyperactivity disorder, Unspecified Type               | F94.1 | Reactive attachment disorder of childhood |