SHORT-DOYLE/MEDI-CAL ORGANIZATIONAL PROVIDER'S MANUAL

for

SPECIALTY MENTAL HEALTH SERVICES

under

THE REHABILITATION OPTION

and

TARGETED CASE MANAGEMENT SERVICES

Original Issue Date: July 1, 1993
Update Effective: January 1, 2024
Revision Date: June 26, 2024

****

LOS ANGELES COUNTY LOCAL MENTAL HEALTH PLAN

Lisa H. Wong, PsyD, Director
Los Angeles County Department of Mental Health

Debbie Innes-Gomberg, PhD, Deputy Director
Quality, Outcomes & Training Division
Compiled by: Quality Assurance Unit

TABLE OF CONTENTS

Chapter 1: Service, Documentation, and Reimbursement Basics

General Service and Reimbursement Rules	6	
Overview	6	6/30/17
Service Philosophy	7	5/6/16
Reimbursement Rules	7	6/26/24
Universal Screening for SMHS	11	9/14/23
Criteria to Access SMHS	14	7/1/22
Medical Necessity for Services	16	7/1/22
Concurrent SMHS and Non-SMHS	16	2/10/23
Co-Occurring Disorders	17	9/14/23
General Documentation Rules	17	6/26/24
Assessment	19	
Description	19	1/1/24
Requirements	19	1/1/24
Timeframes/Frequency	21	1/1/24
Needs Evaluation	22	
Description	22	7/1/22
Requirements	22	7/1/22
Timeframes/Frequency	22	7/1/22
Problem List	23	
Description	23	7/1/22
Requirements	23	7/1/22
Timeframes/Frequency	24	2/10/23
Care Plans	24	
Description	24	7/1/22
Requirements	24	1/1/24
Timeframes/Frequency	26	7/1/22
Informed Consent	27	
Description	27	1/1/24
Requirements	27	1/1/24
Timeframes/Frequency	28	1/1/24
Progress Notes	28	
Description	28	1/1/22
Requirements	28	1/1/24
Timeframes/Frequency	29	1/1/24
Transition of Care	30	
Description	30	9/14/23
Requirements	30	9/14/23
Forms	30	9/14/23
Service Components	31	
Definition	31	11/21/14
Service Components	31	1/1/24

Chapter 2: Services Based on Units of Staff Time (Mode 15)

Service Overview and Reimbursement Rules	38	
Documentation and Claiming Rules	38	9/14/23
Types of Services	39	
Mental Health Services (MHS)	39	6/26/24
Medication Support Services (MSS)	40	6/26/24
Crisis Intervention (CI)	42	6/26/24
Targeted Case Management (TCM)	43	6/26/24
Peer Support Services	45	7/1/22
Services Specific to EPSDT Clients	46	1/1/22
Therapeutic Behavioral Services (TBS)	46	7/1/22
Intensive Care Coordination & Intensive Home Based Services	52	9/14/23
Intensive Care Coordination (ICC)	55	7/1/22
Intensive Home Based Services (IHBS)	57	1/1/24

Chapter 3: Regulations and Requirements for Encounters

Mobile Crisis Services	61	12/27/23

Chapter 4: Regulations and Requirements of Services Based on Blocks of Time (Mode 10)

Service Overview & Reimbursement Rules	65	
General Rules	65	11/21/14
Therapeutic Foster Care Services (TFCS)	65	7/1/22
Crisis Stabilization Services (CS)	69	11/21/14
Day Treatment Intensive (DTI)	71	6/26/24
Day Rehabilitation (DR)	76	6/26/24
Socialization Day Services	80	11/21/14
Vocational Services	81	11/21/14

Chapter 5: Services Based on Calendar Days

Service Overview & Reimbursement Rules	84	
General Rules	84	5/6/16
Adult Residential Services (Transitional and Long-Term)	84	6/26/24
Crisis Residential Treatment Services	87	6/26/24
Psychiatric Health Facility	90	6/26/24
Psychiatric Inpatient Hospital Services	95	6/26/24
Medical Care Evaluation (MCE) Studies for Psychiatric Inpatient Hospitals	101	9/13/23

Chapter 6: Short-Doyle/Medi-Cal Provider Certification

Overview	104	6/30/17
General Requirements	104	6/30/17

Certification Process	105	7/12/21
On-Site Review	106	6/30/17
Certification Checklist and Protocol	109	6/30/17
APPENDIX		
Appendix I - Definitions: Criteria to Access SMHS	111	1/1/22

CHAPTER 1

Service, Documentation, and Reimbursement Basics

GENERAL SERVICE AND REIMBURSEMENT RULES

STANDARDIZED SCREENING PROCESS

CRITERIA TO ACCESS SMHS & MEDICAL NECESSITY FOR SERVICES

CONCURRENT SMHS AND NON-SMHS

CO-OCCURRING DISORDERS

ASSESSMENT

NEEDS EVALUATION

PROBLEM LIST

CARE PLAN

INFORMED CONSENT

PROGRESS NOTES

TRANSITION OF CARE

GENERAL SERVICE AND REIMBURSEMENT RULES

OVERVIEW

Medicaid is a joint federal and state program that helps with medical costs for some people with limited income and resources. In California, the Medicaid program is called Medi-Cal and there is a "carve out" for "specialty mental health services". Specialty Mental Health Services are Rehabilitative Services (which include mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential treatment services, and psychiatric health facility services), Psychiatric Inpatient Hospital Services, Targeted Case Management, Psychiatric Services, Psychologist Services, EPSDT Supplemental Specialty Mental Health Services and Psychiatric Nursing Facility Services (CCR §1810.247). The State Department of Health Care Services (State DHCS) administers the program in California by agreement with the federal Center for Medicare and Medicaid Services (CMS). This agreement is set forth in the State Plan and subsequent amendments. The Los Angeles County Department of Mental Health (LACDMH) acts as the Local Mental Health Plan (hereafter referred to as the MHP), the entity which enters into an agreement (under the State Contract) with the State DHCS to arrange for and/or provide specialty mental health services within the County.

This manual reflects the current requirements for Rehabilitative Services, Targeted Case Management and EPSDT Supplemental Specialty Mental Health Services reimbursed by Medi-Cal as Specialty Mental Health Services and serves as the basis for all documentation and claiming in LACDMH regardless of payer source. Per LACDMH Policy 401.03, all providers, whether Directly-Operated or Contracted, must abide by the information found in this manual. Information referenced in this manual incorporates requirements from the following key sources:

- Code of Federal Regulations (CFR);
- California Code of Regulations (CCR);
- State Plan Amendments (SPA);
- State Contract;
- State DHCS Mental Health Services Division Medi-Cal Billing Manual (Medi-Cal Billing Manual);
- State DHCS Letters and Information Notices;
- DHCS Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS) and Therapeutic Foster Care (TFCS) for Medi-Cal Beneficiaries (Medi-Cal Manual);
- LACDMH Policy and Procedure;
- LACDMH Requirements.

Additional sources may be cited throughout the manual. The symbol "§" placed in the reference denotes "Section" and is followed by the associated regulation's numerical code. All references to a regulatory section from California Code of Regulations are from Title 9, Chapter 11 unless otherwise specified.

While the above cited sources may refer to “beneficiary”, “patient”, or “recipient”, this Manual will universally use the term “client” for consistency.

The Quality Assurance Unit issues Quality Assurance (QA) Bulletins as a way of communicating updates or clarifications to information found in this Manual. QA Bulletins are considered to be official LACDMH requirements and will be incorporated into this Manual as appropriate.

Some funded programs that are not funded by Medi-Cal may allow for reimbursement of services that do not meet the requirements as set forth in this document. Refer to the “Guidelines for Claiming by Funded Program” for additional information on claiming and reimbursement by funded program.

SERVICE PHILOSOPHY AND REQUIREMENTS

Medi-Cal services provided under the federal Rehabilitation Option focus on client needs, strengths, choices and involvement in care planning and implementation. The goal is to help clients take charge of their lives through informed decision-making. Program staffing is multi-disciplinary and reflects the cultural, linguistic, ethnic, age, gender, sexual orientation and other social characteristics of the community that the program serves. Families, caregivers, human service agency personnel and other significant support persons who, in the opinion of the client or the person providing the service, has or could have a significant role in the successful outcome of treatment (CCR §1810.246.1) are encouraged to participate in the planning and implementation process in meeting the client's needs, choices, responsibilities and desires. Programs are designed to use both licensed and non-licensed personnel who are experienced in providing services in the mental health field.

All programs providing specialty mental health services must inform clients and their legal guardians (if applicable) that acceptance and participation in the mental health system is voluntary and shall not be considered a prerequisite for access to other community services. In addition, clients and their legal guardians retain the right to access other Medi-Cal or Short-Doyle/Medi-Cal reimbursable services and have the right to request a change of provider and/or staff person/therapist/case manager at any time.

REIMBURSEMENT RULES

Key Points Applicable to One or More Mode of Services

- 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. (DHCS BHIN 22-019)

- For Medicare clients, there must be documentation in the Clinical Record of consultation, or attempts to consult, with a physician.

- A Provider must either be certified as a Mental Health Rehabilitation Provider (CCR §1810.435) or licensed by State Department of Health Services (DHS) as a Psychiatric Hospital Service, Inpatient Hospital Service, or Outpatient Hospital Service to be eligible for reimbursement for providing Medi-Cal services. See the Certification Guidelines

- Hospital outpatient departments as defined in Title 22, CCR §51112, operating under the license of a hospital may only provide services in compliance with licensing requirements.

- In order to be reimbursed, a Progress Note must be present in the clinical record to provide evidence of each claimed service based on the frequency of progress notes by type of service as noted in the Progress Notes section.

- Every claim must be supported by a progress note that must be present in the clinical record prior to the submission of the claim (State Contract).

- For every service claimed, the practitioner who delivered the service and submitted the claim is attesting that they believe the service is medically necessary. Refer to medical necessity for services later in this chapter.

- Medically necessary/clinically appropriate services are reimbursable during the assessment process prior to determining a diagnosis even if the client ends up not meeting criteria to access SMHS.

- Rehabilitative [all outpatient SMHS except TCM] Mental Health Treatment Services are provided by or under the direction of (for those providers that may direct services) the following mental health providers functioning within the scope of their professional license and applicable state law. (SPA 22-0023)

    - "Under the direction of" means that the individual directing service is acting as a clinical team leader, providing direct or functional supervision of service delivery. An individual directing a service is not required to be physically present at the service site to exercise direction. The licensed professional directing a service assumes ultimate responsibility for the Rehabilitative Mental Health Service and Targeted Case Management service provided. Services are provided under the direction of:
        - A physician;
        - A licensed or waivered psychologist;
        - A licensed, waivered or registered social worker;
        - A licensed, waivered or registered marriage and family therapist;
        - A licensed, waivered or registered professional clinical counselor,
        - A registered nurse (including a certified nurse specialist, or a nurse practitioner), or
        - A licensed occupational therapist (SPA 23-0026).

- Services shall be provided within the scope of practice of the person delivering the service, if professional licensure is required for the service (CCR §1840.314), and his/her employer's job description/responsibility. The local mental health director shall be responsible for assuring that services provided are commensurate with the professionalism and experience of the staff utilized.

- Services provided after the death of a client may not be claimed to Medi-Cal.

- Services should be provided in the setting and manner most appropriate to the treatment and service needs of the client (State DMH Letter No.: 02-07).

- EPSDT Supplemental services (e.g., Therapeutic Behavioral Services) should not be approved if it is determined that the service to be provided is accessible and available in an appropriate and timely manner as another specialty mental health service available from the provider (CCR §1830.210(b)).

- Mental Health Services should not be approved in home and community based settings if it is determined that the total cost incurred for providing such services to the minor is greater than the total cost to the Medi-Cal program in providing medically equivalent services at the minor's otherwise appropriate institutional level of care, where medically equivalent services at the appropriate level are available in a timely manner (CCR §1830.210(c)).

- As with all Medi-Cal services, travel should be individualized to the needs of the client.

- Only direct care is reimbursable: If the service code billed is a client care code, direct client care means time spent with the patient for the purpose of providing healthcare. If the service code billed is a medical consultation code then direct client care means time spent with the consultant/members of the beneficiary's care team. Direct client care does not include travel time, administrative activities, chart review, documentation, utilization review and quality assurance activities or other activities a provider engages in either before or after a patient visit. (SMHS Billing Manual) For additional information, refer to the Guide to Procedure Codes.

- Transportation services are not reimbursable (CCR §1810.355).

- Missed Appointments are not reimbursable (State DMH Letter No.: 02-07). This includes missed appointments at the provider's site, the client's home, or elsewhere in the community. While documenting a missed appointment or a voice mail/telephone message for a client is important, the time, including any travel time, cannot be claimed when no services are provided.

- Services are non-reimbursable by Medi-Cal when:
  - Provided in a jail or prison setting (Title 22, CCR §50273).
  - Provided to persons aged 22 through 64 who are residents of an Institution for Mental Disease (IMD) (CCR §1840.312). An IMD is defined as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged

in providing diagnosis, treatment or care of persons with mental disease, including medical attention, nursing care, and related services (CCR §1810.222.1); (Title 42, CFR, CCR §435.1009). As such, a free standing Psychiatric Hospital or a State Hospital qualifies as an IMD.

- A client under 21 years of age resides in an IMD other than a Psychiatric Health Facility (PHF) that is a hospital or an acute psychiatric hospital, except if the client was receiving such services prior to his/her 21st birthday. If this client continues without interruption to require and receive such services, the eligibility for Federal Financial Participation (FFP) dollars continues to the date he/she no longer requires such services, or if earlier, his/her 22nd birthday (CCR § 1840.312).
- Lock-out rules apply that appear in Chapter subsections of this Manual and restrict conditions of a claim.

- Services provided to children or adolescents in a juvenile hall setting are only reimbursable when the minor has been adjudicated and is awaiting suitable placement (Title 22 CCR §50273 and State DHCS Letter No. 12-2). Judicial legal orders from the court must be issued and indicate that the continuing detention in the juvenile hall setting is for the safety and protection of the minor based on criteria outlined in [WIC §628]; i.e., the minor is not being detained for reasons related to arrest or violation of probation.

- Services of clerical support personnel are not reimbursable (CCR §1830.205). While it may be appropriate at times to record in the clinical record activities or observations of these personnel, their cost is included in overhead rates, for which the Department receives a percent of Medi-Cal reimbursement.

- Clerical activities performed by any staff are not reimbursable. While it is important to document in the clinical record when information is faxed or mailed, these activities are clerical and are not reimbursable. They should be documented in a separate note from the reimbursable service identifying that no time was claimed for these activities.

- Supervision time is not reimbursable. Supervision focuses on the supervisee's clinical/educational growth (as when meeting to monitor his/her caseload or his/her understanding of the therapeutic process) and is NOT reimbursable time. Supervision time required by Department policy or State licensing boards always falls within this definition and, thus, is never reimbursable. If a contact between a supervisor and supervisee does not fall within these definitions, but focuses instead on client needs/planning, the time is not considered supervision and may be claimed.

- Personal care services performed for the client are not reimbursable (State DMH Letter No.: 01-01). These are services provided to a client which they cannot perform for themselves or which the service provider cannot teach the client to perform for themselves. Examples include grooming, personal hygiene, assisting with medication, child or respite care, housekeeping, and the preparation of meals.

- Conservatorship investigations are not reimbursable.

- Payee related services are not reimbursable (CCR §1840.312).

- Vocational, Academic, Educational, Recreational, and Socialization Activities are not reimbursable (CCR §1840.312). Activities which focus on skills specific to vocational training, academic education, recreation, or socialization activity are not reimbursable.
  - Vocational services for the purpose of actual work or work training, whether or not the client is receiving wages are not reimbursable by Medi-Cal.
  - Educational (academic) services where the focus is on learning information for the purpose of furthering one's scholastic ability are not reimbursable.
  - Recreational services which have as their sole purpose relaxation, leisure, or entertainment are not reimbursable.
  - Socialization services which consist of generalized group activities that do not provide systematic individualized feedback to specific targeted behaviors of the clients involved are not reimbursable.
  - When the activities are used to achieve a therapeutic goal, the mental health service that was provided should be documented and is reimbursable by many payers. Reimbursable services can be delivered at a work, academic, or recreational site; as long as the interventions focus on aiding the client to integrate into the community, access necessary resources, or maximize interpersonal skills.

- Translation or interpretive services are not reimbursable.

- Notes must be legible. Notes that are not legible are not reimbursable.

UNIVERSAL SCREENING FOR SPECIALTY MENTAL HEALTH SERVICES (SMHS)

(LACDMH Policy 302.14)

DESCRIPTION

Beneficiaries shall be screened upon initial request for services to identify the mental health delivery system most appropriate for their level of need. The standardized screening process is used by Medi-Cal Managed Care Plans (MCPs) and LACDMH to ensure an efficient and effective referral process based on initial indicators of a beneficiary's mental health needs. The process and tools are designed to guide the referral process to the Medi-Cal MCP for Non-SMHS or LACDMH for SMHS as well as assisting in managing the resources available in each delivery system.

REQUIREMENTS

Screeners shall be administered at first contact when a beneficiary or caregiver on behalf of a youth initially requests outpatient mental health services. Upon completion of screening and referral to the appropriate mental health delivery system, the beneficiary shall receive an assessment from a provider to determine medically necessary mental health services. Throughout the screening, providers should make every effort to engage beneficiaries in the process (i.e., promptly responding to questions or concerns) and in accord with accepted standards of clinical practice, honoring beneficiary consent regarding participation in the process.

All requests by the beneficiary or caregiver originating at the LACDMH 24/7 ACCESS Help Line are required to be screened. If the beneficiary/caregiver requests services directly from a provider (e.g., clinic), the provider is not required to administer the screening, and may begin the assessment process and provide services during the assessment period without using the screeners, consistent with the No Wrong Door for Mental Health Services Policy. However, it is considered best practice for providers to administer the screening tool when clinically appropriate to get the beneficiary to the most appropriate system (Non-SMHS or SMHS) from the outset. At all times, it is important to remember that all beneficiaries have a right to receive an assessment for SMHS and any medically necessary services during the assessment period. If the beneficiary/caregiver does not wish to complete the screening or it is determined to not be clinically appropriate to conduct the screening (e.g., beneficiary unable to meaningfully engage in the process), they shall be referred for a mental health assessment for SMHS and/or other clinically needed services. If upon completion of an assessment, the beneficiary does not meet criteria to access SMHS, they shall be issued an NOABD and transitioned to their MCP for Non-SMHS.

Screening does not replace a clinical assessment, level of care determination, or service recommendations. Additionally, screening does not replace current LACDMH (1) procedures for handling urgent or crisis/emergency care needs, (2) protocols that address clinically appropriate, timely, and equitable access to care, or (3) requirements to provide EPSDT services.

Based on their screening score, the beneficiary shall be referred to the appropriate mental health delivery system (either Non-SMHS through their MCP or SMHS through LACDMH) for a clinical assessment. If a beneficiary is referred to an LACDMH provider, providers must offer and provide a timely clinical assessment per Policy 302.07. Providers may not conduct additional screening. If a beneficiary is referred to the MCP, the completed screener shall be sent to the MCP. Please note that while DHCS requires beneficiaries to be referred based on their screening score, beneficiary safety shall continue to be priority and staff shall continue to ensure beneficiaries are referred for the appropriate services to meet their clinical needs. If the beneficiary/caregiver responds affirmatively to the substance use screening questions, the Department of Public Health Substance Abuse Service Helpline (SASH) number shall be offered. The beneficiary may decline the referral without impact to their mental health delivery system referral. If a beneficiary

under the age of 21 or their caregiver indicates there is a gap in connection to primary care, referral to their MCP shall be offered.

When the completed screener/referral is being sent to the MCP, the beneficiary's authorization is not required. The MCPs are HIPAA-covered entities and participate in an organized health care arrangement.

FORMS

The DHCS standardized screening tools shall be used for the screening in addition to documenting within the Service Request Log (SRL) or Service Request Tracking System (SRTS). The screeners are embedded within the SRTS, and for directly operated providers, the screeners are embedded within the SRL in IBHIS. The screeners include screening questions and an associated scoring methodology. The screening questions must be read verbatim to the beneficiary/caregiver and the order of the questions shall not be altered in any way. If translated versions of the tool are not available, bi-lingual staff may translate the screening questions themselves which may require deviation from the specific wording of the tool.

The Adult Screener shall be used for beneficiaries twenty-one (21) years of age and older and includes screening questions to elicit information about safety, clinical experiences, life circumstances and risk.

The Youth Screener shall be used for beneficiaries under the age of 21 and is available in a Youth version and a Caregiver version. When a youth is requesting services for themselves, the Youth Version shall be used. When a caregiver is requesting services on behalf of a youth, the Caregiver Version shall be used. Both youth versions include questions to elicit information about safety, system involvement, life circumstances, and risk. The Youth Screener includes initial questions that automatically qualify an individual for SMHS (e.g., foster care involvement) which prevents the need to complete additional screening questions. While the additional screening questions are not required, best practice is to continue with the entire screener when clinically appropriate to provide valuable clinical information to the assessing provider. If a third party (other than a caregiver) is requesting services for a beneficiary, the screening tools are not required. If clinically appropriate, the screening tools shall then be administered upon contacting the beneficiary/caregiver prior to entering a disposition in the SRL/SRTS.

The Screeners can be administered by any staff including clinicians or non-clinicians. They may be administered in a variety of ways, including in person, by telephone, or by video conference.

CRITERIA TO ACCESS SPECIALTY MENTAL HEALTH SERVICES (SMHS) & MEDICAL NECESSITY FOR SERVICES

CRITERIA TO ACCESS SMHS

Criteria to Access SMHS is used to determine whether clients are eligible to receive services under the Mental Health Plan (MHP) i.e., within LACDMH. Access criteria for adults differs from access criteria for clients under age 21, with the latter providing broader protection and additional avenues to access SMHS.

CRITERIA FOR CLIENTS 21 AND OLDER TO ACCESS SMHS

(Both of the following must apply - #1 **AND** #2)

1. Client has **one or both** of the following:
   a. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities.
   b. A reasonable probability of significant deterioration in an important area of life functioning.

AND

2. The client's above condition is **due to either of the following**:
   a. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Statistical Classification of Diseases and Related Health problems (ICD).
   b. A suspected mental disorder that has not yet been diagnosed.

CRITERIA FOR CLIENTS UNDER AGE 21 TO ACCESS SMHS

(Either Criteria 1 **OR** Criteria 2)

Criteria 1:

1. The beneficiary has a condition placing them at high-risk for a mental health disorder due to experience of trauma evidenced by any of the following:
   - Scoring in the high-risk range under a trauma screening tool approved by DHCS (pending approval from DHCS)
   - Involvement in the Child Welfare System
   - Juvenile Justice involvement
   - Experiencing homelessness

DHCS definitions for each of the high-risk trauma areas can be found in Appendix I in this manual.

OR

Criteria 2:

2. The beneficiary meets **both** of the following requirements in **a and b** below:
   a. The beneficiary has **at least one** of the following:
      i. A significant impairment

ii. A reasonable probability of significant deterioration in an important area of life functioning iii. A reasonable probability of not progressing developmentally as appropriate iv. A need for SMHS, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide
AND
b. The beneficiary's condition as described above is due to **one of the following**: i. A diagnosed mental health disorder, according to criteria of the current editions of the DSM and ICD ii. A suspected mental health disorder that has not yet been diagnosed iii. Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

NOTE: A neurocognitive disorder (e.g., dementia) or a substance-related and addictive disorder (e.g., stimulant use disorder) are not "mental health disorders" for the purpose of determining whether a beneficiary meets criteria to access the SMHS delivery system. However, LACDMH must cover SMHS for beneficiaries with any of these disorders if they also have a mental health disorder (or suspected mental health disorder not yet diagnosed) and meet criteria for SMHS as described above.

NOTE: While a mental health diagnosis is not a prerequisite to access SMHS, this does not eliminate the requirement that all Medi-Cal claims include a CMS valid ICD-10 diagnosis code. In cases where services are provided due to a suspected mental health disorder that has not yet been diagnosed or due to significant trauma, options are available in the CMS approved ICD-10 diagnosis code list. These include codes for "Other specified" and "Unspecified" disorders, or "Factors influencing health status and contact with health services" (Z codes). These codes will meet ICD-10 claiming requirements and allow for needed mental health care to be provided even while the clinician is determining a diagnosis. IBHIS will accept any valid ICD-10 code under all funding sources.

Clinically appropriate SMHS are reimbursable during the assessment period prior to determining a diagnosis or whether the client meets access criteria for SMHS. Services rendered during the assessment period remain reimbursable even if the assessment ultimately indicates that the client does not meet criteria for SMHS. If at the end of the assessment period (i.e., the presence/absence of an official diagnosis has been determined), it is decided that the Medi-Cal client would be best served in the Managed Care Plan (MCP) for non-specialty mental health services (Non-SMHS), then the LACDMH provider should refer/transition the client to the MCP and can be reimbursed for those care coordination services.

If it is determined that the client does not meet criteria to access SMHS, a Notice of Adverse Benefit Determination (NOABD) Service Delivery must be issued to Medi-Cal beneficiaries in order to provide written notification to explain why the beneficiary's condition does not meet criteria to access SMHS; as well as provide a referral for Non-SMHS, and instructions on how to appeal the decision if they think it is incorrect.

MEDICAL NECESSITY FOR SERVICES

Services provided to a client must be medically necessary and clinically appropriate to address the client's presenting condition. Medical Necessity for both SMHS (i.e., LACDMH) and non-SMHS (i.e., MCP) delivery systems is defined as:

Medical Necessity Clients 21 & Older	Medical Necessity Clients Under Age 21
A service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain WIC Section 14059.5	A service is "medically necessary" or a "medical necessity" when needed to correct or ameliorate a mental health condition *(Note: services do not need to be curative or restorative to ameliorate a mental health condition per CMS)* Federal EPSDT Law – Title 42 USC § 1396d(r)(5)

CONCURRENT SMHS AND NON-SMHS

Based on their level of need, Medi-Cal clients are entitled to receive either Non-Specialty Mental Health Services (Non-SMHS) through the MCPs and/or Specialty Mental Health Services (SMHS) through the LACDMH system of care. The access criteria for MCPs and the types of Non-SMHS they can provide are defined below:

Managed Care Plan Criteria	Managed Care Plan Services (Non-SMHS)
• Medi-Cal clients 21+ w/ mild to moderate distress or mild to moderate impairment of mental, emotional or behavioral functioning resulting from mental health disorders, as defined by the DSM · Medi-Cal clients under 21, to the extent eligible for services through EPSDT, regardless of level of distress or impairment or the presence of a diagnosis · Medi-Cal clients of any age with potential mental health disorders not yet diagnosed.	• Mental health evaluation and treatment, including individual, group and family psychotherapy · Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition · Outpatient services for purposes of monitoring drug therapy · Psychiatric consultation · Outpatient laboratory, drugs, supplies and supplements

Medi-Cal clients may concurrently receive Non-SMHS via an MCP provider and SMHS via an LACDMH provider when the services are clinically appropriate, coordinated and not duplicative. When a Medi-Cal client meets criteria for both Non-SMHS and SMHS, the client should receive services based on individual clinical need and established therapeutic relationships. Any concurrent Non-SMHS and SMHS for adults, as well as

children under 21 years of age, must be coordinated between MCPs and LACDMH to ensure beneficiary choice.

Medi-Cal clients with established therapeutic relationships with an LACDMH provider may continue receiving SMHS from that provider, even if they simultaneously receive Non-SMHS from an MCP provider, as long as the services are coordinated and non-duplicative (e.g., a Medi-Cal client may only receive psychiatry services in one network, not both networks; a Medi-Cal client may only access individual therapy in one network, not both networks).

The decision to refer a Medi-Cal client to the MCP should be made via a client-centered and shared decision making process. When referring a client to the MCP, LACDMH providers must ensure that the MCP provider accepts the referral. (DHCS BHIN 22-011) Refer to QA Bulletin 22-11 for additional information regarding transitioning care to an MCP.

CO-OCCURRING DISORDERS

Clinically appropriate and covered SMHS are reimbursable even if the client has a co-occurring disorder (e.g., substance use, cognitive, medical disorders). SMHS will not be disallowed simply because the client has a co-occurring disorder as long as all other requirements are met. LACDMH providers may address the client's substance use or other disorder as long as it is in support of treating the clients mental health condition. The session must primarily address the beneficiary's mental health, e.g., symptom, condition, diagnosis, and/or risk factors, which can include co-occurring SUD (DHCS No Wrong Door and Co-Occurring Disorder FAQ). LACDMH providers may not provide stand-alone SUD services.

GENERAL DOCUMENTATION RULES

- All Providers must refer and adhere to LACDMH Policy 401.02 and 401.03.

- All LACDMH Directly-Operated Providers must use the DMH approved forms or an approved electronic health record system for documentation. LACDMH Contract Providers must incorporate all LACDMH required documentation elements as referenced in this Manual and adhere to the forms guidelines identified in DMH Policy 401.02.

- All Directly-Operated Providers must refer and adhere to the LACDMH Clinical Records Guidelines.

- Special client needs as well as associated interventions directed toward meeting those needs must be documented (LACDMH Policy 401.03):
    - Visual and hearing impairments
    - Client's whose primary language is not English - Clients should not be expected to provide interpretive services through friends or family members. (See LACDMH Policy #200.03, "Language Interpreters", for further information.).

Oral interpretation and sign language services must be available free of charge (State Contract)

NOTE: Just because assistance is documented, it does not necessarily mean it is claimable. Claimed notes for services must show how the service assists the client in accessing services or is a service intervention. The assistance must be claimed in accord with the focus of the client contact and the staff providing the service. Simply translating for the client is not considered an intervention.

NOTE: In order to obtain and/or transmit linguistically accurate information from clients who do not speak English as a first language, the Department has translated some of its forms into other languages. Whenever non-English forms are used, the English translation version must be printed on the back of the form. If that is not possible, the English version must be placed immediately adjacent to the non-English version in the clinical record. The English version should note that the document was signed on the non-English version.

- Cultural and/or linguistic considerations - When special cultural and/or linguistic needs are present, there must be documentation in the clinical record indicating the plan to address the cultural and/or linguistic needs.
  - If an exception is made to the identified plan for addressing cultural and/or linguistic needs, there must be documentation in the progress note addressing the exception and how it was handled.

NOTE: Culture is "the integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics. Culture defines:

- How health care information is received;
- How rights and protections are exercised;
- What is considered to be a health problem;
- How symptoms and concerns about the problem are expressed;
- Who should provide treatment for the problem; and
- What type of treatment should be given (*U.S. Department of Health and Human Services, Office of Minority Health (2013); The National Culturally and Linguistically Appropriate Services (CLAS) Standards.*)

Cultural considerations may include but are not limited to: racial/ethnic/national origin, religious/spiritual background or affiliation, gender/sexual orientation, other cultural considerations expressed by the consumer.

- Registered and/or waivered staff must be supervised by a licensed practitioner within scope of practice in accordance with laws and regulations governing the registration or waiver. (CCR §1840.314)

- Applicants for registration as an Associate Marriage and Family Therapist, Associate Professional Clinical Counselor, or Associate Clinical Social Worker (Associate) meeting all requirements of the Board of Behavioral Sciences (BBS) 90-day rule who have completed their Live Scan and are awaiting their registration number may provide and claim Medi-Cal for assessment and therapy services.
  - Post-degree hours and claiming to Medi-Cal for assessment and therapy services may only be counted as of the "Live Scan Transaction Completed" date recorded at the bottom of the Request for Live Scan Service form.
  - To begin claiming for these services, Associates must be properly set up in NAPPA and proof of registration sent to the Quality Assurance Unit.
  - In the event the BBS application is not approved by BBS, all services provided by the candidate are not Medi-Cal reimbursable.

- Co-signatures may **NEVER** be used to allow a staff person to perform a service that is not within his/her scope of practice. Co-signing a document means the co-signer has supervised the service delivery and assumes responsibility and liability for the service.
    - Services provided by clinical trainees (a formal written agreement between the school and the Legal Entity must be in place for staff to be considered a clinical trainee) must have all documentation co-signed by a licensed individual acting within their scope of practice.
    - Services provided by unlicensed staff without a bachelor's degree in a mental health related field **or** two (2) years of mental health experience (paid or unpaid) delivering services must have all documentation co-signed by a licensed individual acting within their scope of practice until the experience/education requirement is met and the supervisor has determined that the staff person is competent to provide services and document independently.

NOTE: If the staff person requires co-signature, it must be on every document the staff signs.

ASSESSMENT
(LACDMH Policy 401.03)

DESCRIPTION

An Assessment is important in the beginning to understand and appreciate who the client is and the interrelationship between the client's symptoms/behaviors and the client as a whole person. The Assessment enables the reader to see the role of culture and ethnicity in the client's life and documents the impact of significant supports, living situation, substance use, etc. on the mental health of the client. The Assessment identifies the client and his/her family's strengths and identifies the stages of change/recovery for the client. The formulation collected in an Assessment allows the client and staff to collaborate in the development of a mutually agreed upon plan of treatment and recovery.

Note: Crisis Assessments completed during crisis intervention, crisis stabilization or mobile crisis services do not need to meet the comprehensive assessment requirements outlined in this section.

REQUIREMENTS

Assessments must contain the required seven (7) uniform Assessment domains (categories of information) as identified below to the extent information is available. There is no requirement for the domains to be laid out in this manner. For clients under the age of 21, the Child and Adolescent Needs and Strengths (CANS) Assessment tool may be utilized to help inform the Assessment domain requirements but is not sufficient as the Assessment in-and-of itself. The domains shall be documented on an Assessment form or other documentation form (i.e., initial medication note) and shall be kept within the client's clinical record.

The Child/Adolescent Full Assessment, Infancy, Childhood & Relationship Enrichment Initial Assessment (ICARE), Adult Full Assessment, and Immediate/Same Day Assessment all meet requirements of the seven domains and may be utilized by any provider as the Assessment.

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

The assessment shall include the licensed practitioner's recommendation for medically necessary services and additional provider referrals, as clinically appropriate.
NOTE: The problem list and progress note requirements shall support the medical necessity of each service provided.

The diagnosis, Mental Status Exam (MSE), medication history, and assessment of relevant conditions and psychosocial factors affecting physical and mental health must be completed by a practitioner, operating within their scope of practice, who is licensed, registered/waivered, and/or under the direction of a licensed mental health professional (i.e., clinical trainee professionals in these disciplines with co-signature).

Providers may designate certain other qualified practitioners to contribute to the Assessment consistent with their scope of practice, including gathering mental health and medical history, substance exposure and use, and identifying strengths, risks, and barriers to achieving goals. For DO providers, this information is documented in a Progress Note and reviewed with the primary assessing clinician, who then enters the relevant information into the Assessment form.

Domain 1
• Presenting Problem(s) • Current Mental Status • History of Presenting Problem(s) • Client-Identified Impairment(s)
Domain 2
• Trauma
Domain 3
• Behavioral Health History (including Substance Use History) • Co-occurring Substance Use (i.e., substance use & mental health)
Domain 4
• Medical History • Current Medications • Co-occurring Conditions other than substance use (i.e., medical & mental health)

Domain 5
• Social and Life Circumstances • Culture/Religion/Spirituality
Domain 6
• Strengths, Risk Behaviors & Protective Factors
Domain 7
• Clinical Summary & Recommendations • Diagnostic Impression • Medical Necessity Determination/Level of Care/Access riteria

TIMEFRAMES / FREQUENCY

- Initial and subsequent Assessments should be completed within a reasonable period of time and in accordance with generally accepted standards of practice. Practitioners shall use their clinical expertise to complete initial assessments as expeditiously as possible in accordance with each client's clinical needs. Efforts should be made to quickly complete the Assessment in order to move the client into treatment.

- All assessment documentation must be completed within the timeframes identified within DMH Policy 401.02.

- Medically necessary services may be provided prior to the initiation or completion of the Assessment. Refer to DMH Policy 302.01 First Service Contacts.

    - In situations where a non-diagnosing practitioner is the first point of contact, an assessment by a diagnosing practitioner should generally be started within five (5) service contacts and/or thirty (30) days of treatment unless there is a clear clinical rationale as to why this did not occur. Once the assessment is completed, the diagnosis must be updated with the most appropriate diagnosis by the assessing/diagnosing practitioner.

    - If crisis intervention is the first contact, best practice is to refer the client to a practitioner that can fully assess the mental health needs of the client and provide on-going treatment beyond the crisis intervention.

- Although not the standard course of action, under certain limited circumstances (e.g., the client is running out of medication) the Initial Medication Evaluation (IME) may serve as the Assessment if the MD/NP/DO is the most appropriate first contact for the client. Please note that in these instances, the IME should focus on a broad evaluation of the client's needs as is the case with the standard Assessment. A practitioner operating within scope is not required to complete an Assessment in addition to the IME unless there is clinical justification to further assess the client.

- The frequency of the Assessment is up to clinical discretion. When there is additional information gathered, whether a change or addition, after the completion of the Assessment, this change or addition would be documented on the Problem List. If it is determined that another Assessment is needed, existing information should be reviewed and incorporated into the Assessment to minimize redundancy in questioning.

    - If a diagnosis requires updating post-Assessment, information supporting the new diagnosis may be documented in a progress note and/or Assessment. For Directly-Operated providers, if a progress note is used to document the supporting information, it is recommended that the progress note supporting the change in diagnosis is referenced in the remarks field of the Diagnosis Form.

- If a provider is accepting a client referred or transferred from another provider, the accepting provider may choose to do an Assessment or use the Assessment from the referring provider based on clinical judgment. If a client is coming back into treatment, the provider may choose to do an Assessment based on clinical judgment, taking into account factors such as the period of time that has elapsed since the client was last seen, the age of the client, and whether the client's current symptoms are consistent with the prior diagnosis. If it is determined that another Assessment is needed, existing information should be reviewed and incorporated to minimize redundancy in questioning.

NEEDS EVALUATION

(LACDMH Policy 401.03)

DESCRIPTION

A Needs Evaluation is a comprehensive assessment and periodic re-assessment of a client's functioning and needs to determine the need for establishment or continuation of Targeted Case Management (TCM) services. It should include, but not limited to: history and current status of need(s); relevant information from other sources; and any barriers to getting needs met (State Plan Amendment). It is conducted to identify areas in the client's life in which ancillary resources or services are needed in order to improve the client's level of functioning and provide sufficient supports to sustain stability.

REQUIREMENTS

For all newly active clients for whom it is determined that criteria to access SMHS has been met, a Needs Evaluation shall be completed. Best practice is to incorporate it into the assessment and take it into account as part of the diagnostic formulation.

If using the LACDMH paper forms, the Needs Evaluation Tool (NET) should be used for ages 21 and older; the Child and Adolescent Needs and Strengths (CANS-IP) should be used for ages 6 through 20; and the CANS-IP or CANS 0-5 should be used for ages 0 through 5. Directly-Operated Providers in the Integrated Behavioral Health Information System (IBHIS) should use the age-appropriate form i.e., NET, CANS-IP or CANS 0-5. Contractors with an EHRS should use the age-appropriate forms with all required data elements as identified on the relevant forms.

NOTE: Newly Active Client is a new client requiring the opening of a new clinical record or an existing client returning for services after the termination of services per DMH Policy No. 312.01, Clinical Termination of Mental Health Services.

TIMEFRAMES / FREQUENCY

For clients 21 and over who are receiving TCM services, a Needs Evaluation must be conducted annually, at minimum.

For clients ages 6 through 20, whether or not they are receiving TCM services, a Needs Evaluation must be conducted every 6 months (QA Bulletin 19-02)

For clients ages 0 to 5 who are receiving TCM services, a Needs Evaluation must be conducted every 6 months.

PROBLEM LIST
(LACDMH Policy 401.03)

DESCRIPTION

The Problem List is a snapshot of a client's problems that represents significant symptoms and needs identified during the assessment and throughout the course of the client's treatment. It provides a global view of the client's issues that the treatment team, or anyone coming in contact with the client, should be aware of without requiring them to go to the assessment or other documentation within the clinical record. The Problem List also creates a method of quickly sharing information to coordinate care with other providers and agencies.

DMH recognizes that "Problem List" is not a strength-based term; however, it is a widely recognized term-of-art used nationally as well as within the healthcare community. It will be retained in-order-to remain consistent with physical health care system language for care coordination and integration. This does not mean that providers should only focus on the client's problems. A client's strengths are identified in the Assessment, CANS, NET, and progress notes and should continue to be capitalized upon throughout treatment.

REQUIREMENTS

The Problem List must contain:

- Symptoms, conditions, diagnoses, social drivers and/or risk factors identified through the Assessment, diagnostic evaluation, crisis encounters, or other types of service encounters;
- Diagnoses identified by a practitioner acting within their scope of practice, if any;
- Problems identified by a practitioner acting within their scope of practice, if any;
- Problems or illnesses identified by the client and/or significant support person, if any;
- The name and title of the provider that identified, added, or removed the problem, and the date the problem was identified, added, or removed.

While a code set for the Problem List is not required, a standard-based coding system such as the CORE Problem List subset of SNOMED CT is highly recommended for future interoperability and coordination of care requirements.

Any practitioner on the treatment team can add problems to the Problem List as it is a reporting form, not a diagnosing form.

TIMEFRAMES / FREQUENCY

The Problem List shall be updated on an ongoing basis to reflect the current presentation of the client, adding or removing problems when there is a relevant change to a client's condition and as new problems are identified. The Problem List shall be updated within a reasonable time and in accordance with generally accepted standards of practice. There are no specific timeframes or frequency in with the problem list must be updated after a problem has initially been added.

CARE PLANS

(LACDMH Policy 401.03)

DESCRIPTION

Care planning is an integral part of providing clinical services. Care planning with clients is a standard of practice which helps to organize and guide treatment. Care plans assist in ensuring clients continue to move forward on a path to recovery by helping the treatment team to monitor progress and make treatment adjustments when necessary. Care planning is not a one-time activity and should be done continuously throughout the course of treatment.

REQUIREMENTS

While care planning should be done for all services, the following services require a care plan and the specific elements that must be documented in the care plan are noted below:

- Targeted Case Management (TCM) and Intensive Care Coordination (ICC) – The care plan must:
    - Specify the goals and actions to address the medical, social, educational, and other services needed by the client
    - Ensure the active participation of the client and working with the client (or the client's authorized health care decision maker) and others to develop those goals.
    - Identify a course of action to respond to the assessed needs of the eligible individual.
- Peer Support Services – The care plan must:
    - Be a comprehensive, individualized plan of care that includes specific individualized goals;
    - Use a person-centered planning process to help promote client ownership of the care plan
        - Such methods actively engage and empower the client, and individuals selected by the client, in leading and directing the design

of the service plan and ensure that the plan reflects the needs and preferences of the client in achieving the
    - Have specific, individualized goals that have measurable results and are specified in the service plan.
- Therapeutic Behavioral Services (TBS) – The care plan must:
    - Be developed by the treatment team;
    - Outline what the child/youth, the family/caregiver and the TBS specialist will do during TBS, and when and where TBS will occur;
    - Identify and describe the challenging behaviors that need to change and the replacement behaviors the TBS specialist will teach the child/youth and family/caregivers;
    - State when the TBS specialist will work with the child/youth and family/caregivers.

In addition, the following facilities and programs have specific documentation requirements related to the care plan.

- Children's Crisis Residential Programs (CCRP) https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/MHSUDS_Information_Notice_19-004_CCRP/CCRMHP_Interim_Standards.pdf
- Community Treatment Facilities (CTF) https://govt.westlaw.com/calregs/Document/I4D6551634C6B11EC93A8000D3A7C4BC3?viewType=FullText&listSource=Search&originationContext=Search+Result&transitionType=SearchItem&contextData=(sc.Search)&navigationPath=Search%2fv1%2fresults%2fnavigation%2fi0ad720f20000018928c9f91036571dc8%3fppcid%3dd3e28271c0d846fa8dd78f6a01a09d8b%26Nav%3dREGULATION_PUBLICVIEW%26fragmentIdentifier%3dI4D6551634C6B11EC93A8000D3A7C4BC3%26startIndex%3d1%26transitionType%3dSearchItem%26contextData%3d%2528sc.Default%2529%26originationContext%3dSearch%2520Result&list=REGULATION_PUBLICVIEW&rank=1&t_T1=9&t_T2=1927&t_S1=CA+ADC+s#co_anchor_I9A4DB0A07D2811EDAC25C189FE32BF3A
- Mental Health Rehabilitation Centers (MHRC) https://govt.westlaw.com/calregs/Document/I43B32BB44C6B11EC93A8000D3A7C4BC3?viewType=FullText&listSource=Search&originationContext=Search+Result&transitionType=SearchItem&contextData=(sc.Search)&navigationPath=Search%2fv1%2fresults%2fnavigation%2fi0ad720f10000018928cbeb3e10336b91%3fppcid%3dff1164fe58d3442eb95127edc2ffe0fb%26Nav%3dREGULATION_PUBLICVIEW%26fragmentIdentifier%3dI43B32BB44C6B11EC93A8000D3A7C4BC3%26startIndex%3d1%26transitionType%3dSearchItem%26contextData%3d%2528sc.Default%2529%26originationContext%3dSearch%2520Result&list=REGULATION_PUBLICVIEW&rank=7&t_T1=9&t_T2=786&t_S1=CA+ADC+s
- Mental Health Services Act Full-Service Partnership (FSP) Individual Services and Supports Plan (ISSP) https://govt.westlaw.com/calregs/Document/I4F948D734C6B11EC93A8000D3A7C4BC3?viewType=FullText&listSource=Search&originationContext=Search+Result&transitionType=SearchItem&contextData=(sc.Search)&navigation

Path=Search%2fv1%2fresults%2fnavigation%2fi0ad720f20000018928cf6df536571e2f%3fppcid%3d95318c70838e4193b78da22a800efdd9%26Nav%3dREGULATION_PUBLICVIEW%26fragmentIdentifier%3dI4F948D734C6B11EC93A8000D3A7C4BC3%26startIndex%3d1%26transitionType%3dSearchItem%26contextData%3d%2528sc.Default%2529%26originationContext%3dSearch%2520Result&list=REGULATION_PUBLICVIEW&rank=1&t_T1=9&t_T2=3620&t_S1=CA+ADC+s

- Short-Term Residential Therapeutic Programs (STRTPs) https://www.dhcs.ca.gov/Documents/STRTP-Regulations-version-II.pdf
- Social Rehabilitation Programs (SRPs) including programs certified by DHCS for:
  - Short-Term Crisis Residential Treatment
  - Transitional Residential Treatment and
  - Long Term Residential Treatment

  https://govt.westlaw.com/calregs/Document/I3E2B00A34C6B11EC93A8000D3A7C4BC3?viewType=FullText&listSource=Search&originationContext=Search+Result&transitionType=SearchItem&contextData=(sc.Search)&navigationPath=Search%2fv1%2fresults%2fnavigation%2fi0ad720f20000018928dfaaf636571f2c%3fppcid%3d449328a2431640b3ae53424bd6314cd6%26Nav%3dREGULATION_PUBLICVIEW%26fragmentIdentifier%3dI3E2B00A34C6B11EC93A8000D3A7C4BC3%26startIndex%3d1%26transitionType%3dSearchItem%26contextData%3d%2528sc.Default%2529%26originationContext%3dSearch%2520Result&list=REGULATION_PUBLICVIEW&rank=1&t_T1=9&t_T2=532.2&t_S1=CA+ADC+s

For the above services and programs, providers must adhere to all relevant care planning requirements in state or federal law.

All required elements of the care plan for the above services shall be documented in the clinical record. For example, required care plan elements may be notated within the assessment, problem list, or progress notes, or a dedicated care plan template within an Electronic Health Record.

To support delivery of coordinated care, the content of the care plan must be able to be produced and communicated to other providers, the client, and Medi-Cal behavioral health delivery systems, in accordance with applicable state and federal privacy laws.

TIMEFRAMES / FREQUENCY

For services that require a documented care plan, there shall be periodic revision of the care plan.

INFORMED CONSENT
(DHCS BHIN 23-065)

DESCRIPTION

Informed consent is when the client is informed of the nature, risks, benefits and alternatives to treatment. In regulations, informed consent is only required for antipsychotic medications within specific types of facilities (DHCS BHIN 23-065). However, generally accepted practice is for those prescribing/furnishing medical services and medications to go through the process of informed consent.

For information on general consent for services, refer to DMH Policy 302.01: First Service Contact

REQUIREMENTS

When psychiatric medications are prescribed, there must documentation in the Clinical Record that:

- Information about informed consent to medications (as described below) has been discussed with the client by the prescribing physician
  - (a) The nature of the patient's mental condition,
  - (b) The reasons for taking such medication, including the likelihood of improving or not improving without such medication, and that consent, once given, may be withdrawn at any time by stating such intention to any member of the treating staff,
  - (c) The reasonable alternative treatments available, if any,
  - (d) The type, range of frequency and amount (including use of PRN orders), method (oral or injection), and duration of taking the medications,
  - (e) The probable side effects of these drugs known to commonly occur, and any particular side effects likely to occur with the particular patient,
  - (f) The possible additional side effects which may occur to patients taking such medication beyond three months. The patient shall be advised that such side effects may include persistent involuntary movement of the face or mouth and might at times include similar movement of the hands and feet, and that these symptoms of tardive dyskinesia are potentially irreversible and may appear after medications have been discontinued.
- The client understands the nature and effect of the medications

If medications are to be administered to client or the medications are prescribed in a residential or inpatient setting, there must also be a written record documenting verbal consent to the administration of medications.

For programs whose clients are dependents or wards (children and youth under the jurisdiction of the Juvenile Court), the JV-220 through JV-223 forms may be utilized as the Informed Consent. Use of the JV-220 through JV-223 forms may require additional documentation within the clinical record to ensure a-f above were addressed in informed consent.

Directly-Operated programs shall document within the applicable progress note that informed consent was provided. If a signature by the client is needed to clearly document that informed consent was provided, the Medication Consent form may be utilized in addition to the progress note.

TIMEFRAMES / FREQUENCY

Informed consent shall be done at the point of prescribing medications by the prescribing/furnishing practitioner.

PROGRESS NOTES
(LACDMH Policy 401.03)

DESCRIPTION

Progress Notes provide a means of communication and continuity of care between all service delivery staff as well as provide evidence of the course of the client's illness and/or condition. Progress Notes are used to describe the medically necessary Specialty Mental Health Service provided.

REQUIREMENTS

Per DHCS BHIN 23-068, the content of the progress note shall:

a) Support the service code(s) selected and support effective clinical care and coordination among providers. 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. 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.
b) Include a brief description of how the service addressed the member's behavioral health needs (e.g., symptom, condition, diagnosis, and/or risk factors).
c) Document a brief summary of next steps including, but not limited to, planned action steps by the practitioner or by the client, collaboration with the client, collaboration with other provider(s) and any update to the Problem List as appropriate

In addition, progress notes must include the following minimum data elements:

- The type of service rendered;
- The date that the service was provided to the client;
- Duration of the Direct Care for the service;
- Location / Place of Service;
- A typed or legibly printed name, signature (or electronic equivalent) of the service practitioner and date of signature.

Claims must include the following information which must be clearly associated with each encounter and consistent with the description in the progress note. However, they are not required to be included in the progress note narrative.

- Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code;
- ICD 10 code (the ICD 10 code is not required to be on the progress note but must appear in the clinical record, associated with each encounter and consistent with the description in the progress note);

When a group service is rendered, a list of participants is required to be documented and maintained by the practitioner. In addition, for group services specifically, the progress note must include a brief description of the client's response to the service (in addition to requirements noted above).

Should more than one practitioner render a service, either to a single client or to a group, at least one progress note per client must be completed. The note must be signed by at least one practitioner. The progress note shall clearly document the specific involvement and duration of direct patient care for each practitioner of the service.

NOTE: Any Mental Health Services (MHS) or Medication Support Services provided to a client in Day Treatment Intensive or Day Rehabilitation must have the start and end time of the face to face contact documented to ensure that the time spent providing these services is not counted toward the total hours/minutes the client actually attended the program (LACDMH).

NOTE: It is best practice to complete a discharge summary as part of a collaborative process with the client and/or significant support during an in person contact or, minimally, a phone contact.

Progress notes must be completed by the practitioner who provided the service and acting within his/her scope of practice and in accord with the Guide to Procedure Codes.

TIMEFRAMES / FREQUENCY

Progress notes shall be documented within the timeframes identified in DMH Policy 401.02 Clinical Records Contents and Documentation Entry.

Progress notes shall be documented at the frequency by type of service indicated below:

- Every claim (minimally)
  - ✓ Mental Health Services
  - ✓ Medication Support Services
  - ✓ Crisis Intervention
  - ✓ Targeted Case Management
  - ✓ Intensive Care Coordination
  - ✓ Intensive Home Based Services
  - ✓ Therapeutic Behavioral Services
  - ✓ Mobile Crisis Services

  NOTE: See also Documentation and Claiming in Chapter 2 & 3.

- Daily
  - ✓ Crisis Residential
  - ✓ Adult Residential
  - ✓ Crisis Stabilization
  - ✓ Day Treatment Intensive
  - ✓ Day Rehabilitation
  - ✓ Therapeutic Foster Care

TRANSITION OF CARE

DESCRIPTION

When the beneficiary's condition changes, transition of care is needed to smoothly transition the beneficiary to the most appropriate mental health delivery system (Non-SMHS through MCP or SMHS through LACDMH) to meet their needs. In order to facilitate a smooth transition, providers shall provide clinical information to the new system and continue seeing the beneficiary until they are connected. Throughout the transition of care process, providers should make every effort to engage beneficiaries in the process and in accord with accepted standards of clinical practice, honoring beneficiary consent regarding agreement to transition to the other system of care.

REQUIREMENTS

Beneficiaries shall be transitioned to Non-SMHS through their MCP when the beneficiary no longer meets criteria to access SMHS and is in need of a lower level of care. For additional assistance in identifying when a beneficiary may be ready for transition, the questions and scoring from the screening tools may be utilized. Please note there may be situations in which it is clinically appropriate to transition only a subset of the beneficiaries' services to the MCP or vice versa.

After the Transition of Care form is completed, the LACDMH provider will send it over to the MCP via fax or email. Providers shall ensure that the referral process has been completed and the beneficiary has been connected with a MCP provider. Providers shall continue providing medically necessary services until the new MCP provider has accepted the care of the beneficiary and services have been made available. If an existing DMH client is transitioning to the MCP, the client's authorization is not required given they have previously signed the consent for services and Notice of Privacy Practices per DMH Policy 500.02.

FORMS

The DHCS Transition of Care form is designed to be used for both adults and youth alike. The form, which is used by both LACDMH providers and the MCPs, shall initiate a transition to the MCP and provide clinical information to the receiving provider. The

information shall be collected and documented in the order it appears on the Transition of Care form, and additional information shall not be added to the forms but may be included as attachments.

The Transition of Care form includes specific fields to document the:

- Referring plan contact information and care team;
- Beneficiary demographics and contact information;
- Beneficiary behavioral health diagnosis, cultural and linguistic requests, presenting behaviors/symptoms, environmental factors, behavioral health history, medical history, and medications; and
- Services requested and receiving plan contact information.

The Transition of Care form may be completed by any staff; however, the determination to transition the beneficiary must be made by any Medi-Cal practitioner through a patient-centered shared decision-making process.

The Transition of Care does not replace a clinical assessment, level of care determination, or service recommendations. Additionally, Transition of Care does not replace current LACDMH (1) procedures for handling urgent or crisis/emergency care needs, (2) protocols that address clinically appropriate, timely, and equitable access to care, or (3) requirements to provide EPSDT services.

SERVICE COMPONENTS

(State Plan Amendments)

DEFINITION

Service components are defined in the State Plan Amendment and State Contract and identify the reimbursable elements of Specialty Mental Health Services of the California Medicaid program. Service components are not procedure codes. Procedure codes are part of the HIPAA Transaction and Codes Set for compliant claiming and utilize two nationally recognized coding systems: Current Procedural Terminology (CPT) codes and the Level II Health Care Procedure Code System (HCPCS). Federally defined CPT or HCPCS codes are used for HIPAA compliant claims to identify a specific service. While service components are always reimbursable, procedure codes may or may not be reimbursable.

SERVICE COMPONENTS

All definitions are from the DHCS State Plan Amendment (SPA) unless otherwise noted. Service components lacking specific SPA definitions shall meet the standards of a medically necessary service. The following service components apply to Mode 5, 10 and 15 services as identified in Chapters 2, 3 and 4.

Adjunctive Therapies: Therapies in which both staff and clients participate, such therapies may utilize self-expression, such as art, recreation, dance, or music, as the therapeutic intervention. Participants do not need to have any level of skill in the area of self-expression, but rather be able to utilize the modality to develop or enhance skills directed toward achieving client plan goals. Adjunctive therapies assist the client in attaining or restoring skills which enhance community functioning including problem solving, organization of thoughts and materials, and verbalization of ideas and feelings. Adjunctive therapies provided as a component of Day Rehabilitation or Day Treatment Intensive are used in conjunction with other mental health services in order to improve the outcome of those services consistent with the client's needs identified in the client care plan.

Assessment (Mental Health Services): A service activity designed to collect information and evaluate the current status of a client's mental, emotional, or behavioral health to determine whether Rehabilitative Mental Health Services are medically necessary and to recommend or update a course of treatment for that beneficiary. Assessments shall be conducted and documented in accordance with applicable State and Federal statutes, regulations, and standards.

Assessment (Targeted Case Management): A service activity to determine the need for establishment or continuation of targeted case management services to access any medical, educational, social or other services. Assessment activities may include: taking client history, identifying the client's needs and completing related documentation, reviewing all available medical, psychosocial, and other records, and gathering information from other sources such as family members, medical providers, social workers, and educators to form a complete assessment of the client and assessing support network availability, adequacy of living arrangements, financial status, employment status, and potential training needs.

Assessment (Therapeutic Behavioral Service): An activity conducted by a provider to assess a child/youth's current problem presentation, maladaptive at risk behaviors that require TBS, member class inclusion criteria, and clinical need for TBS services. Periodic re-assessments for continued medical necessity and clinical need for TBS should also be recorded as TBS. (TBS Manual)

Community Meetings: Meetings that occur at a minimum once a day, but may occur more frequently as necessary, to address issues pertinent to the continuity and effectiveness of the therapeutic milieu. Community meetings actively involve staff and clients. For Day Treatment Intensive, meetings include a staff person whose scope of practice includes psychotherapy. For Day Rehabilitation, meetings include a staff person who is a physician, a licensed/waivered/registered psychologist, clinical social worker, professional clinical counselor, or a marriage and family therapist, a registered nurse, a psychiatric technician, a licensed vocational nurse, or a mental health rehabilitation specialist. Meetings address relevant items including the schedule for the day, current events, individual issues clients or staff wish to discuss to elicit support of the group, conflict resolution within the milieu, planning for the day, the week or for special events, follow-up business from previous meetings or from previous day treatment experiences,

and debriefing or wrap-up. Community meetings in the context of the therapeutic milieu are intended to assist the client towards restoration of their greatest possible level of functioning consistent with the client's needs identified in the client care plan by providing a structured and safe environment in which to practice strategies and skills which enhance the client's community functioning, including but not limited to, isolation reducing strategies, communication skills particularly in terms of expressing the client's needs and opinions, problem solving skills, and conflict resolution skills. (State Contract)

Crisis Assessment (Mobile Crisis): To evaluate the current status and environment of the client experiencing the behavioral health crisis with the goal of mitigating any immediate risk of danger, determining a short-term strategy for restoring stability, and identifying appropriate follow-up care.

Crisis Intervention: An unplanned, expedited service, to or on behalf of a client to address a condition that requires more timely response than a regularly scheduled visit. Crisis intervention is an emergency response service enabling a client to cope with a crisis, while assisting the client in regaining their status as a functioning community member. The goal of crisis intervention is to stabilize an immediate crisis within a community or clinical treatment setting.

NOTE: Crisis Intervention is both a service component and type of service under Mode 15.

Crisis Planning (Mobile Crisis): To develop a plan to avert future crises, including identifying conditions and factors that contribute to a crisis, reviewing alternative ways of responding to such conditions and factors, and identifying steps that the beneficiary can take to avert or address a crisis.

Educational Skill Building Groups: Providing a supportive environment in which clients and their families learn coping mechanisms and problem-solving skills in order to help the client achieve desired outcomes. These groups promote skill building for the beneficiaries in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.

Engagement: Activities and coaching to encourage and support clients to participate in behavioral health treatment. Engagement may include supporting beneficiaries in their transitions and supporting beneficiaries in developing their own recovery goals and processes.

Evaluation of Clinical Effectiveness and Side Effects

Evaluation of the Need for Medication

Facilitation of a Warm Handoff (Mobile Crisis): If the client requires urgent treatment in an alternative setting. The mobile crisis team must identify an appropriate facility or provider, and provide or arrange for transportation, as needed.

Follow Up Check-ins (Mobile Crisis): To continue resolution of the crisis, provide further crisis planning, check on the status of referrals, and provide further referrals to ongoing supports.
Medication Education: Includes the instruction of the use, risks, and benefits of and alternatives for medication

Medication Support Services: A service that includes prescribing, administering, dispensing and monitoring drug interactions and contraindications of psychiatric medications or biologicals that are necessary to alleviate the suffering and symptoms of mental illness. This service may also include assessing the appropriateness of reducing medication usage when clinically indicated.

NOTE: Medication Support Services is both a service component and type of service under Mode 15.

Mobile Crisis Response (Mobile Crisis): Consisting of an expedited on-site intervention with a client experiencing a behavioral health crisis with the goal of stabilizing the individual within a community setting and de-escalating the crisis.

Monitoring and Follow Up: Activities and contacts necessary to ensure the Client Treatment Plan is implemented and adequately addresses the client's needs. This activity includes at least annual monitoring to determine:

- Services are provided in accordance with the Client Treatment Plan;
- Services in the Client Treatment Plan are adequate;
- If there are changes in the needs or status of the client, there are necessary adjustments in the Client Treatment Plan and service arrangements with providers.

Planning and Assessment of Strengths and Needs: Gathering information and determining the needs of the child/youth and family including strengths and underlying needs, ensuring plans from any of the system partners (e.g. mental health, child welfare, juvenile probation, special education) are integrated to comprehensively address the identified goals and objectives, and coordinating services to support and ensure successful and enduring change. (Medi-Cal Manual)

Process Groups: Groups facilitated by staff to help clients develop skills necessary to deal with their individual problems and issues by using the group process to provide peer interaction and feedback in developing problem-solving strategies and to assist one another in resolving behavioral and emotional problems. (State Contract)

Reassessment of Strengths and Needs: Reassessing the strengths and needs of the child/youth, at least every 90 days and as needed, to determine if changes are needed to continue to support and address the needs of the child/youth. Continually monitoring intervention strategies incorporating approaches that work and refining those that do not. (Medi-Cal Manual)

Referral and Linkages: Services and supports to connect a client with primary care, specialty medical care, substance use disorder treatment providers, mental health providers, and community-based services and supports. This includes identifying

appropriate resources, making appointments, and assisting a client with a warm handoff to obtain ongoing support. (State Plan Amendment)

Referral and Related Activities: To help a client obtain needed services including activities that help link a client with medical, alcohol and drug treatment, social, educational providers or other programs and services that are capable of providing needed services; to intervene at the onset of a crisis to coordinate/arrange for provision of other needed services; to identify, assess and mobilize resources to meet the client's needs including consultation and intervention on behalf of the client with Social Security, schools, social services and health departments, and other community agencies; placement coordination services when necessary to address the identified mental health condition, including assessing the adequacy and appropriateness of the client's living arrangement.

Referral, Monitoring, and Follow-up Activities: Monitoring and adapting is the practice of evaluating the effectiveness of the plan; assessing circumstances and resources; and reworking the plan, as needed. Referral, linkages, monitoring, and follow up activities, to ensure that the child's/youth's needs are met. This includes ensuring that services are being furnished in accordance with the child's/youth's client plan, and that services are adequate to meet the child's/youth's needs. (Medi-Cal Manual)

Referrals to Ongoing Supports (Mobile Crisis): By identifying and connecting a beneficiary to ongoing behavioral health treatment, community-based supports, social services, and/or other supports that could mitigate the risk of future crises. This may include identifying appropriate services, making referrals or appointments, and otherwise assisting a beneficiary to secure ongoing support.

Psychosocial Rehabilitation: A recovery or resiliency focused service activity which addresses a mental health need. This service activity provides assistance in restoring, improving, and/or preserving a client's functional, social, communication, or daily living skills to enhance self-sufficiency or self-regulation in multiple life domains relevant to the developmental age and needs of the beneficiary. Psychosocial rehabilitation includes assisting clients to develop coping skills by using a group process to provide peer interaction and feedback in developing problem-solving strategies. In addition, psychosocial rehabilitation includes therapeutic interventions that utilize self-expression such as art, recreation, dance or music as a modality to develop or enhance skills. These interventions assist the client in attaining or restoring skills which enhance community functioning including problem solving, organization of thoughts and materials, and verbalization of ideas and feelings. Psychosocial rehabilitation also includes support resources, and/or medication education. (State Plan Amendment)

NOTE: Rehabilitation may include medication education in those situations in which Medication Support Service requirements are not met.

Skill Building Groups: In these groups, staff shall help clients identify barriers related to their psychiatric and psychological experiences. Through the course of group interaction, clients identify skills that address symptoms and increase adaptive behaviors. (State Contract)

Therapy: Therapeutic intervention that focuses primarily on symptom reduction and restoration of functioning as a means to improve coping and adaptation and reduce functional impairments. Therapeutic intervention includes the application of cognitive, affective, verbal or nonverbal, strategies based on the principles of development, wellness, adjustment to impairment, recovery and resiliency to assist a beneficiary in acquiring greater personal, interpersonal and community functioning or to modify feelings, thought processes, conditions, attitudes or behaviors which are emotionally, intellectually, or socially ineffective. These interventions and techniques are specifically implemented in the context of a professional clinical relationship. Therapy may be delivered to a client or group of clients and may include family therapy directed at improving the client's functioning and at which the client is present. (State Plan Amendment)

Therapeutic Activity: A structured non-clinical activity to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the client's treatment to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the client; promotion of self-advocacy; resource navigation; and collaboration with the clients and others providing care or support to the client, family members, or significant support persons.

Therapeutic Behavioral Service (TBS) Intervention: An individualized one-to-one behavioral assistance intervention to accomplish outcomes specifically outlined in the written TBS client plan. A TBS intervention can be provided either through face-to-face intervention or by telephone; however, a significant component of this service activity is having the staff person on-site and immediately available to intervene for a specified period of time. (TBS Manual)

Therapeutic Milieu: A therapeutic program structured by process groups and skill building groups that has activities performed by identified staff; takes place for the continuous hours of program operation; includes staff and activities that teach, model and reinforce constructive interactions; and includes peer and staff feedback to clients on strategies for symptom reduction, increasing adaptive behaviors, and reducing adjunctive distress. It includes behavior management interventions that focus on teaching self-management skills that children, youth, adults, and older adults may use to control their own lives, deal effectively with present and future problems, and function well with minimal or no additional therapeutic intervention. (State Contract)

Transition: Developing a transition plan for the child/youth and family to promote long term stability including the effective use of natural supports and community resources. (Medi-Cal Manual)

Treatment Planning: Developing or updating a client's course of treatment, documentation of the recommended course of treatment, and monitoring a client's progress. (State Plan Amendment)

CHAPTER 2

Regulations and Requirements for Services Based on Minutes of Staff Time (Mode 15)

SERVICE OVERVIEW & REIMBURSEMENT RULES
- **Documentation and Claiming Rules**

TYPES OF SERVICES
- **Mental Health Services (MHS)**
- **Medication Support Services (MSS)**
- **Crisis Intervention (CI)**
- **Targeted Case Management (TCM)**
- **Therapeutic Behavioral Services (TBS)**
- **Intensive Care Coordination (ICC)**
- **Intensive Home Based Services (IHBS)**

SERVICE OVERVIEW & REIMBURSEMENT RULES

DOCUMENTATION AND CLAIMING RULES

(See also Chapter 1, "General Documentation Rules" and subsequent sections for specific rules related to specific services.)

Documentation and Claiming:

To ensure multiple encounters of the same service to the same client on the same day by the same practitioner are not denied as duplicate services, a single claim shall be submitted combining the duration of the contacts. (DHCS Billing Manual) For example, if a practitioner provides psychotherapy for crisis to a client for 30 minutes in the morning and provides psychotherapy for crisis to the same client for 30 minutes in the afternoon, the claim would be submitted for 60 minutes for psychotherapy for crisis. Because most electronic health record systems generate claims based on progress notes, a single progress note may be written indicating the total duration of the contacts as well as the content of all contacts for that day. Documentation should be clear that there were multiple contacts. If it is not possible to write a single progress note due to the first note having already been finalized at the point of the second contact, providers may write a second note so long as the added total duration of the two contacts is on one claim to prevent claim denials.

- If during a single service contact multiple activities occur (e.g., Therapy and Targeted Case Management or Targeted Case Management and Rehabilitation) a single progress note may be written and a single claim submitted using the procedure code that describes the primary service provided.

- The total time claimed shall not exceed the actual time utilized for claimable services (CCR §1840.316).

- In no case shall the units of time reported or claimed for any one person exceed the hours worked (CCR §1840.316).

- A service is an individual service when services are directed towards or on behalf of only one client.

- A service is a group service when services are directed towards or on behalf of more than one client at the same time.

- A separate claim must be submitted for each client involved in a group. The units claimed should be the same for all clients in the group using the total duration of direct care for the group. The same code shall also be used on each claim.

- Separate claims must be submitted for each practitioner providing a service. (DHCS Billing Manual)

- When services are being provided to or on behalf of a client by two or more practitioners in a single contact each practitioner's involvement shall be documented in the context of the mental health needs of the client. (CCR §1840.314). This may be documented in a single note so long as the practitioners provided the same service.

TYPES OF SERVICES

MENTAL HEALTH SERVICES

Definition (State Plan Amendment):

Mental Health Services are individual, group or family-based interventions that are designed to provide reduction of the client's mental or emotional disability, restoration, improvement and/or preservation of individual and community functioning, and continued ability to remain in the community consistent with the goals of recovery, resiliency, 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.

Mental Health Services may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the beneficiary.

Mental Health Services may be provided face-to-face, by telephone or by telehealth and may be provided anywhere in the community

Service Components (State Plan Amendment):

Mental Health Services include one or more of the following service components:

- Assessment
- Treatment Planning
- Therapy
- Psychosocial Rehabilitation

Claiming (Mode, Service Function and Procedure Code Reference):

Mental Health Services are claimed under Mode 15. Mental Health Services include the following Service Function Codes:

- 42 – Individual

- 52 – Group
- 34 – Psychological Testing
- 44 – Fee For Service MHS

Refer to the Guide to Procedure Codes for a complete listing of procedure codes and disciplines which may be claimed as Mental Health Services. Mental Health Services shall be claimed in accord with Scope of Practice and the Guide to Procedure Codes.

Certain psychological tests may be claimed as individual tests or if part of a test battery depending on individual circumstances (i.e., if anticipated to be a stand-alone test or part of a battery) (see Guide to Procedure Codes).

Medi-Cal Lockouts:

- Mental Health Services are not reimbursable on days when Crisis Residential Treatment Services (CCR §1840.364), Psychiatric SD/MC Inpatient Hospital Services (CCR §1840.215), Psychiatric Health Facility Services (CCR §1840.370) or Adult Residential Treatment Services (DHCS Billing Manual v1.4 and DHCS SMHS Service Table v2.0) are reimbursed, except on the day of admission to any of these facilities. **Note:** The date of discharge is not reimbursable in the above facilities and thus Mental Health Services can be claimed on the day of admission <u>and</u> discharge from these facilities.

- Mental Health Services are not reimbursable when provided by Day Rehabilitation or Day Treatment Intensive staff during the same time period that Day Rehabilitation or Day Treatment Intensive Services are being provided (CCR §1840.360).

- Mental Health Services are not reimbursable when provided during the same time that Crisis Stabilization-Emergency Room or Urgent Care is provided. (CCR §1840.368).

- Providers may not allocate the same staff's time under the two cost centers of Adult Residential and Mental Health Services for the same period of time (CCR §1840.362).

MEDICATION SUPPORT SERVICES

Definition (State Plan Amendment):

Medication support services include prescribing, administering, dispensing and monitoring drug interactions and contraindications of psychiatric medications or biologicals that are necessary to alleviate the suffering and symptoms of mental illness. This service may also include assessing the appropriateness of reducing medication usage when clinically indicated.

Medication support services may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the beneficiary.

Medication support services may be provided face-to-face, by telephone or by telehealth and may be provided anywhere in the community. Medication support services may be delivered as a standalone service or as a component of crisis stabilization.

Service Components (State Plan Amendment):

Medication Support Service components include one or more of the following service components:

- Evaluation of the need for medication
- Evaluation of clinical effectiveness and side effects of medication
- Medication education including instruction in the use, risks and benefits of and alternatives for medication
- Treatment Planning

Claiming (Mode, Service Function and Procedure Code Reference):

Medication Support Services are claimed under Mode 15. Medication Support Services include the following Service Function Codes:

- 62 – Medication Support

Refer to the Guide to Procedure Codes for a complete listing of procedure codes which may be claimed as Medication Support Services. Medication Support Services shall be claimed in accord with Scope of Practice and the Guide to Procedure Codes.

Medi-Cal Lockouts:

- Medication Support Services are not reimbursable on days when Psychiatric Inpatient Services (CCR §1840.215) or Psychiatric Health Facility Services (CCR §1840.370) are reimbursed, except for the day of admission to either service. **Note:** The date of discharge is not reimbursable in the above facilities and thus Medication Support Services can be claimed on the day of admission <u>and</u> discharge from these facilities.

- A maximum of four hours of Medication Support Services per client per calendar day is Medi-Cal reimbursable (CCR §1840.372).

Additional Information:

In addition to the Documentation Requirements noted in Chapter 1 and the beginning of Chapter 2, the following documentation and claiming rules apply:

- Medication Support Services that are provided as an adjunct to a Residential or Day Treatment Intensive/Day Rehabilitation program shall be billed separately from that service.

- When Medication Support Services are provided to a client by a physician and nurse concurrently, the time of both staff should be claimed. If both staff provide the same service (e.g., medication education), then one note may be written that covers both staff. If two staff provide different services during the contact (e.g., the physician writes a prescription and the nurse gives an injection), two notes should be written.

- If a staff person ineligible to claim Medication Support Services participates in the medication related contact, then the ineligible staff person must write a separate note documenting service time as either Targeted Case Management or Mental Health Services, in accord with the service the staff provided.

CRISIS INTERVENTION

Definition (State Plan Amendment):

Crisis Intervention is an unplanned, expedited service, to or on behalf of a client to address a condition that requires more timely response than a regularly scheduled visit. Crisis intervention is an emergency response service enabling a client to cope with a crisis, while assisting the client in regaining their status as a functioning community member. The goal of crisis intervention is to stabilize an immediate crisis within a community or clinical treatment setting.

Crisis intervention may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the beneficiary.

Crisis intervention may be provided face-to-face, by telephone or by telehealth and may be provided in a clinic setting or anywhere in the community.

Service Components (State Plan Amendment)

Crisis Intervention service components include:

- Assessment
- Therapy
- Referral and Linkages

Claiming (Mode, Service Function and Procedure Code Reference):

Crisis Intervention is claimed under Mode 15. Crisis Intervention includes the following Service Function Codes:

- 77 – Crisis Intervention

Refer to the Guide to Procedure Codes for a complete listing of procedure codes which may be claimed as Crisis Intervention. Crisis Intervention shall be claimed in accord with Scope of Practice and the Guide to Procedure Codes.

Medi-Cal Lockouts (CCR §1840.366):

- Crisis Intervention is not reimbursable on days when Crisis Residential Treatment Services, Psychiatric Health Facilities Services, Psychiatric Nursing Facility Services, or Psychiatric Inpatient Hospital Services are reimbursed, except for the day of admission to those services. **Note:** The date of discharge is not reimbursable in the above facilities and thus Crisis Intervention can be claimed on the day of admission and discharge from these facilities.

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

Additional Information:

In addition to the Documentation Requirements noted in Chapter 1 and the beginning of Chapter 2, the following documentation and claiming rules apply:

- The acuity of the client or situation which jeopardizes the client's ability to maintain community functioning must be clearly documented.

- If an out-of-office situation is presented to a responding staff member as a crisis and the staff member finds the situation not to be a crisis upon arrival, the service may still be claimed as Crisis Intervention if the crisis described in the originating call is so documented.

TARGETED CASE MANAGEMENT

Definition (State Plan Amendment):

Targeted Case Management means services that assist a client to access needed medical, alcohol and drug treatment, educational, social, prevocational, vocational, rehabilitative, or other community services.

Targeted Case Management includes the following assistance:

1. Comprehensive assessment and periodic reassessment of individual needs to determine the need for establishment or continuation of targeted case management services to access any medical, educational, social or other services.
2. Development and periodic revision of a plan to access the medical, social, educational, and other services needed by the client.

3. Referral and related activities.
4. Monitoring and follow-up activities.

Service Components (State Plan Amendment):

Targeted Case Management service components include:

- Assessment
- Plan Development
- Referral and Related Activities
- Monitoring and Follow-Up

Claiming (Mode, Service Function and Procedure Code Reference):

Targeted Case Management is claimed under Mode 15. Targeted Case Management includes the following Service Function Codes:

- 04 – Targeted Case Management

Refer to the Guide to Procedure Codes for a complete listing of procedure codes which may be claimed as Targeted Case Management. Targeted Case Management shall be claimed in accord with Scope of Practice and the Guide to Procedure Codes.

Medi-Cal Lockouts (CCR §1840.374):

- 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 below:
    - 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 client on discharge from the 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: Coordinating placement may include identifying and securing a placement, and setting up mental health services to support successful placement upon discharge from the hospital, psychiatric health facility or psychiatric nursing facility.

NOTE: Targeted Case Management **is reimbursable** during the same time Crisis Stabilization is provided. (No other specialty mental health service is reimbursable during the same period Crisis Stabilization is reimbursed.) (CCR §1840.368)

⇒ Targeted Case Management Services are not reimbursable when provided to a client who is receiving services in an Institution for Mental Diseases (IMD) except for clients aged 21 and younger receiving services as described in 42 CFR 440.160 and clients

aged 65 and older receiving services described in 42 CFR 440.140 (State Plan Amendment)

Additional Information (DHCS IN 22-019):

Targeted case management services require the development (and periodic revision) of a specific care plan within the progress note that is based on the information collected through the assessment. The TCM care plan:

- ✓ Specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual;
- ✓ Includes activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals;
- ✓ Identifies a course of action to respond to the assessed needs of the eligible individual;
- ✓ Includes development of a transition plan when a beneficiary has achieved the goals of the care plan. (42 CFR 482.169(d))

(Refer also to Chapter 1 Needs Evaluation and Care Planning)

PEER SUPPORT SERVICES

Definition (State Plan Amendment):

Peer Support Services are culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals. Services aim to prevent relapse, empower clients through strength-based coaching, support linkages to community resources, and to educate clients and their families about their conditions and the process of recovery.

Peer support services can include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the client by supporting the achievement of the client's treatment goals. Peer support services are based on an approved plan of care.

Service Components (State Plan Amendment):

Peer Support service components include:

- Educational Skill Building Groups
- Engagement
- Therapeutic Activity

Claiming (Mode, Service Function and Procedure Code Reference):

Peer Support is claimed under Mode 15. Peer Support includes the following Service Function Codes:

- 01 – Peer Support

Refer to the Guide to Procedure Codes for a complete listing of procedure codes which may be claimed as Peer Support. Peer Support shall only be claimed by Certified Peer Specialists and in accord with the Guide to Procedure Codes.

Medi-Cal Lockouts (CCR §1840.374):

- Peer Support Services are not provided in an institution for mental disease (IMD).

Additional Information (State Plan Amendment):

- Services must be provided by Peer Support Specialists. A Peer Support Specialist is an individual with a current State-approved Medi-Cal Peer Support Specialist Certification Program certification and must meet ongoing education requirements. Peer Support Specialists provide services under the direction of a Behavioral Health Professional.

- Peer support services must be based on an approved care plan. The plan shall be documented within the progress notes and approved by any treating provider who can render reimbursable SMHS services. (Refer also to Chapter 1 Care Planning) (DHCS IN 22-019 & State Plan Amendment)

SERVICES SPECIFIC TO Early & Periodic Screening, Diagnostic and Treatment (EPSDT) CLIENTS

EPSDT Supplemental services (e.g., Therapeutic Behavioral Services) should **not** be approved if it is determined that the service to be provided is accessible and available in an appropriate and timely manner as another specialty mental health service available from the provider (CCR §1830.210(b)).

THERAPEUTIC BEHAVIORAL SERVICES

Therapeutic Behavioral Services (TBS) are supplemental specialty mental health services covered under EPSDT. TBS is an intensive, individualized, one-to-one behavioral mental health service available to children/youth with serious emotional challenges and their families, who are under 21 years old and have full-scope Medi-Cal.

Target Population (TBS Manual):

Class criteria requirements include:

- The child/youth is under the age of 21 and has Full Scope Medi-Cal
- The child/youth is placed in a group home facility of RCL 12 or above or in a locked treatment facility for the treatment of mental health needs; OR
- The child/youth is being considered for placement in an RCL 12 or above (whether or not an RCL 12 or above placement is available) or a locked treatment facility for the treatment of mental health needs (whether or not the psychiatric facility is available); OR
- The child/youth has undergone at least one emergency psychiatric hospitalization related to his/her current presenting mental health diagnosis within the preceding 24 months; OR
- The child/youth has previously received TBS while a member of the certified class; OR
- The child/youth is at risk of psychiatric hospitalization.

NOTE: Therapeutic Behavioral Services (TBS) are an EPSDT Supplemental Specialty Mental Health Service (CCR §1810.215). TBS is never a primary therapeutic intervention; it is always used in conjunction with a primary specialty mental health service (TBS Manual).

Definition (TBS Manual unless otherwise noted):

TBS is a one-to-one behavioral mental health service available to children/youth with serious emotional challenges who are under 21 years old and who are eligible for a full array of Medi-Cal benefits without restrictions or limitations (full scope Medi-Cal). TBS can help children/youth and parents/caregivers, foster parents, group home staff, and school staff learn new ways of reducing and managing challenging behaviors as well as strategies and skills to increase the kinds of behavior that will allow children/youth to be successful in their current environment. TBS are designed to help children/youth and parents/caregivers (when available) manage these behaviors utilizing short-term, measurable goals based on the needs of the child/youth and family. TBS are never a stand-alone therapeutic intervention. They are used in conjunction with another [specialty] mental health service. (DHCS Information Notice No: 08-38)

TBS can be provided anywhere in the community: at home, school, other places such as after-school programs and organized recreation programs, except during Medi-Cal lockouts.

TBS is not allowable when:

1. Services are solely:
   - For the convenience of the family or other caregivers, physician, or teacher;
   - To provide supervision or to assure compliance with terms and conditions of probation;

- To ensure the child/youth's physical safety or the safety of others, e.g., suicide watch; or
- To address behaviors that are not a result of the child/youth's mental health condition.

2. The child/youth can sustain non-impulsive self-directed behavior, handle him/herself appropriately in social situations with peers, and appropriately handle transitions during the day

3. The child/youth will never be able to sustain non-impulsive self-directed behavior and engage in appropriate community activities without full-time supervision.

4. The child/youth is currently admitted on an inpatient psychiatric hospital, psychiatric health facility, [psychiatric] nursing facility, IMD, or crisis residential program.

5. On-Call Time for the staff person providing TBS (note, this is different from "non-treatment" time with staff who are physically "present and available" to provide intervention – only the time spent actually providing the intervention is a billable expense).

6. The TBS staff provides services to a different child/youth during the time period authorized for TBS.

7. Transporting a child or youth. (Accompanying a child or youth who is being transported may be reimbursable, depending on the specific, documented, circumstances).

8. TBS supplants the child or youth's other mental health services provided by other mental health staff.

Service Components (TBS Manual):

TBS include one or more of the following service components:

- Assessment (TBS)
- Plan Development
- TBS Intervention
- Collateral

Claiming (Mode, Service Function and Procedure Code Reference):

TBS is claimed under Mode 15. TBS includes the following Service Function Codes:

- 58 – Therapeutic Behavioral Service

Refer to the Guide to Procedure Codes for a complete listing of procedure codes and disciplines which may be claimed as TBS. TBS shall be claimed in accord with Scope of Practice and the Guide to Procedure Codes.

Medi-Cal Lockouts (TBS Manual):

- TBS is not reimbursable on days when Crisis Residential Treatment Services, Inpatient Psychiatric Services, [Psychiatric Nursing Facility] or Psychiatric Health Facility Services are reimbursed by Medi-Cal, except for the day of admission to the facility. Note: The date of discharge is not reimbursable in the above facilities and thus TBS can be claimed on the day of admission and discharge from these facilities.

- TBS is not reimbursable during the same time period that Crisis Stabilization is reimbursed by Medi-Cal.

Additional Information (TBS Manual):

Supplemental TBS Assessment

In addition to meeting the criteria to access SMHS and assessment requirements set forth in Chapter 1, any TBS recipient requires a Supplemental TBS Assessment be completed prior to the initiation of TBS that verifies the TBS recipient meets TBS "class criteria" requirements and is eligible to receive TBS services except as allowed in number three (3) below.

The Supplemental TBS Assessment must be signed by an Authorized Mental Health Discipline. If using the LACDMH paper forms, the Supplemental TBS Assessment should be used. For Contractors with an EHRS, the relevant form with all the required data elements listed on the LACDMH paper form should be used.

1. Authorization Requirements (DHCS Information Notice No.: 19-026)

   TBS services must be authorized by the Department prior to delivery and claiming.

   Providers must request authorization by submitting the Supplemental TBS Assessment form indicating the clinical need for the service and signed by an Authorized Mental Health Discipline (refer to Clinical Forms Bulletin 20-04).

   For subsequent authorization requests, an updated Supplemental TBS Assessment form indicating the current clinical need for the service and signed by an Authorized Mental Health Discipline.

   For Contracted providers, the documents must be submitted via the Provider Connect module of the Integrated Behavioral Health Information System (IBHIS).

   Once the pre-authorization request is submitted, LACDMH will approve or deny the request within five (5) business days. If a provider determines, as indicated on the supplemental assessment form, that the standard timeframe could seriously jeopardize the client's life or health or ability to attain, maintain, or regain maximum

functioning, LACDMH will make an expedited authorization decision within 72 hours. Once pre-authorized, services shall be authorized for a 6-month period or 15,000 minutes, whichever comes first. Providers must submit an additional request for authorization prior to the end of the pre-authorized period if the client is to continue with services.

An authorization is valid for any TBS within a Legal Entity for a given Funding Source. A subsequent authorization request must be submitted when (1) an authorization expires and the client continues to need the service, (2) the client switches to a new Funding Source, or (3) a different Legal Entity will be providing TBS. A subsequent authorization is NOT needed when a client moves between provider/service locations within a Legal Entity.

2. Staff Qualifications

Staff providing TBS services should be trained in functional behavioral analysis with an emphasis on positive behavioral interventions.

3. Thirty (30) Day Unplanned TBS Contact

The LACDMH may conditionally authorize the provision of TBS for a maximum of 30 calendar days when class membership cannot be established for a child/youth. This may be done:

- Up to 30 days or until class membership is established, whichever comes first; or
- When the child/youth presents with urgent or emergency conditions that jeopardize his/her current living arrangement.

The need for authorization when class membership cannot be established would be indicated by marking “Expedited Request Needed” on the Supplemental TBS Assessment form

NOTE: An emergency condition is a condition that meets the criteria in CCR §1820.205 and when the client with a condition, due to a mental disorder, is a danger to self or others, or immediately unable to provide for or utilize, food, shelter or clothing, and requires psychiatric inpatient hospital or psychiatric health facility services (CCR §1810.216). An urgent condition means a situation experienced by a client that, without timely intervention, is certain to result in an immediate emergency psychiatric condition CCR §1810.253).

4. Client Treatment Plan and Transition Plan

Any TBS recipient requires a written client treatment plan for TBS as part of the standard Client Treatment Plan for Specialty Mental Health Services (see Chapter 1). The following elements must be identified in the Client Treatment Plan for TBS to be provided:
Note: The standard Client Treatment Plan form may be used to document the following elements.

- Targeted Behaviors: Clearly identified specific behaviors that jeopardize the residential placement or transition to a lower level of residential placement and that will be the focus of TBS.
- Plan Goals: Specific, observable and/or quantifiable goals tied to the targeted behaviors.
  NOTE: On the Client Treatment Plan, this would be the same as an objective.
- Benchmarks: The objectives to be met as the child/youth progresses towards achieving client plan goals.
- Interventions: Proposed intervention(s) expected to significantly diminish the targeted behaviors, including:
  - A specific plan of intervention for each of the targeted behaviors or symptoms identified in the assessment and the client plan, which is developed with the family/caregiver, if available, and as appropriate.
  - A specific description of the changes in the behaviors that the interventions are intended to produce, including an estimated time frame for these changes.
  - A specific way to measure the effectiveness of the intervention at regular intervals and documentation of refining the intervention plan when the original interventions are not achieving expected results.
- Transition Plan: A transition plan that describes the method the treatment team will use to decide how and when TBS will be decreased and ultimately discontinued, either when the identified benchmarks have been reached or when reasonable progress towards goals/benchmarks is not occurring and, in the clinical judgment of the treatment team developing the plan, are not reasonably expected to be achieved. This plan should address assisting parents/caregivers/school personnel with skills.
  NOTE: The Transition Plan may be documented in a Progress Note so long as it is clearly identified as the "Transition Plan".
  - Transitional Age Youth (TAY): As necessary, includes a plan for transition to adult services when the beneficiary is no longer eligible for TBS and will need continued services. This plan addresses assisting parents/caregivers with skills and strategies to provide continuity of care when TBS is discontinued, as appropriate in the individual case.
  - If the beneficiary is between 18 and 21 years of age, include notes regarding any special considerations that should be taken into account.

5. Progress Notes

In addition to the Progress Note requirements set forth in Chapter 1, TBS progress notes should clearly document the occurrence of the specific behaviors which threaten the stability of the current placement or interfere with the transition to a lower level of residential placement, and the interventions provided to ameliorate those behaviors/symptoms.

A TBS progress note should exist for every TBS contact including:

- Direct one-to-one TBS service
- TBS Assessment and/or Reassessment

- TBS Collateral contact (see CCR Title 9 Section 1810.206)
- TBS Plan of Care/Client Plan or its documented review/updates

INTENSIVE CARE COORDINATION & INTENSIVE HOME BASED SERVICES

Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) are specialty mental health services covered under EPSDT. ICC is a targeted case management service that facilitates assessment of, care planning for and coordination of services. IHBS are mental health rehabilitation services aimed at helping the child/youth build skills necessary for successful functioning in the home and community and improving the child/youth's family's ability to help the child/youth successfully function in the home and community. These services are available to children/youth, when medically necessary, to correct or ameliorate mental illnesses or conditions through the EPSDT benefit.

NOTE: *A child/youth is not required to be enrolled in an intensive program (e.g., Full Service Partnership or Wraparound) in order for the child or youth to receive ICC and/or IHBS.*

Target Population (Medi-Cal Manual)

Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) are provided through the EPSDT benefit to all children and youth who:

- Are under the age of 21,
- Are eligible for the full scope of Medi-Cal services; and

Meet criteria to access specialty mental health services (see Chapter 1 in this manual)

MHPs must make individualized determinations of need for ICC and IHBS based on each child or youth's strengths and needs. As discussed below, these services are appropriate for children and youth with more intensive needs or who are in or at risk of placement in residential or hospital settings but who could be effectively served in the home or community.

ICC and IHBS are very likely to be medically necessary for children and youth who meet the following criteria. These criteria are not requirements or conditions, but are provided as guidance in order to assist in identifying children and youth who are in need of ICC and IHBS.

ICC and IHBS are very likely to be medically necessary for children and youth who:

a) Are receiving, or being considered for Wraparound, Intensive Field Capable Clinical Services (IFCCS), Full Service Partnership (FSP) or Intensive Services Foster Care (ISFC);
b) Are receiving, or being considered for specialized case rate due to behavioral health needs;

c) Are being considered for other intensive SMHS, including but not limited to TBS or crisis stabilization or crisis intervention;
d) Are currently in or being considered for high-level-care institutional settings such as group homes (RCL 10 or above) or Short Term Residential Therapeutic Programs (STRTP);
e) Have been discharged within 90 days from, or currently in or being considered for, placement in a psychiatric hospital or 24-hour mental health treatment facility (e.g., psychiatric inpatient hospital, psychiatric health facility (PHF), community treatment facility, etc.);
f) Have experienced two or more mental health hospitalizations in the last 12 months;
g) Have experienced one or more placement changes within 24 months due to behavioral health needs;
h) Have been treated with two or more antipsychotic medications at the same time over a three-month period;
i) If the child is zero through five years old and has more than one psychotropic medication, the child is six through 11 years old and has more than two psychotropic medications, or the child is 12 through 17 years old and has more than three psychotropic medications;
j) If the child is zero through five years old and has more than one mental health diagnosis, the child is six through 11 years old and has more than two mental health diagnoses, or the child is 12 through 17 years old and has more than three mental health diagnoses;
k) Have two or more emergency room visits in the last 6 months due to primary mental health condition or need, including but not limited to involuntary treatment under California Welfare and Institutions Code section 5585.50;
l) Have been detained pursuant to W&I sections 601 and 602 primarily due to mental health needs; or
m) Have received SMHS within the last year and have been reported homeless within the prior six months.

ICC is intended to link clients to services provided by other child-serving systems, to facilitate teaming, and to coordinate mental health care. If a client is involved with two or more child-serving systems, MHPs should utilize ICC to facilitate cross-system communication and planning.

To effectively provide ICC and IHBS, providers should utilize the principles of the Integrated Core Practice Model (ICPM). Specifically, there must be a Child and Family Team (CFT) established to guide the services.

Integrated Core Practice Model (Medi-Cal Manual)

The Integrated Core Practice Model (ICPM) builds on the foundation of the Core Practice Model, and is a set of practices and principles that provide practical guidance and direction to the delivery of timely, effective, and collaborative services to children/youth and their families. The ICPM sets specific expectations for practice behaviors for staff involved in direct services to children/youth and their families, as well as for supervisory and leadership staff. The ICPM values and principles are summarized as follows:

- Children and youth are first and foremost protected from abuse and neglect and maintained safely in their homes.
- Services allow children and youth to achieve stability and permanence in their home and community-based living situations.
- Services are needs-driven, strengths-based, and family-focused from the first conversation with or about the family.
- Services are individualized and tailored to the strengths and needs of each child or youth and their family.
- Services are delivered with multi-agency collaboration that is grounded in a strong, shared preference for community-based services and resources.
- Family voice, choice, and preference are assured throughout the process and can be seen in the development of formal plans and intervention strategies where the child or youth and family have participated in the design.
- Services incorporate a blend of formal and informal resources designed to assist families with successful transitions beyond system services that ensure long-term success.
- Services are respectful of and informed by the culture of the children, youth and their families.
- Services and supports are provided in the child or youth and family's local community and in the least restrictive and most normative settings.

Please refer to the Core Practice Model Guide for additional information regarding the Integrated Core Practice Model.

Child and Family Team (Medi-Cal Manual)

The Child and Family Team (CFT) is central to the Integrated Core Practice Model. The CFT is comprised of the child or youth and family and all of the ancillary individuals who are working with them to address the child or youth's needs and strengths, and focused on issues such as successful treatment of the child or youth's mental health needs and achieving goals in other child-serving systems in which the child or youth is involved.

The CFT is a team that shares a vision with the family and is working to advance that vision, while a CFT meeting is how the members communicate. Mental health staff and service providers, in coordination with any ancillary individuals from child-serving agencies involved in the child or youth's treatment, must utilize a CFT when providing ICC and IHBS.

The CFT composition always should include the child or youth, family members, and representatives from the following (as appropriate to every child or youth and his/her family):

- A representative from the placing agency;
- A representative of the child's or youth's tribe or Indian custodian;
- A representative of the mental health provider/treatment team;
- A foster family agency social worker;
- A short-term residential therapeutic program (STRTP) representative;

- Youth partners/mentors or parent partners;
- Public health providers;
- Court Appointed Special Advocates; and/or
- School personnel.

In addition to formal supports, effective CFT processes support and encourage family members to invite the participation of individuals who are part of their own network of informal support. The may include extended family, friends, neighbors, coaches, clergy, co-workers, or others who the child/youth and/or family have identified as a potential source of support.

Please refer to the Integrated Core Practice Model Guide for additional information regarding Child and Family Teams.

INTENSIVE CARE COORDINATION

Definition (Medi-Cal Manual):

Intensive care coordination (ICC) is similar to the activities routinely provided as Targeted Case Management (TCM); [however], ICC services must be delivered using a CFT to develop and guide the planning and service delivery process. Although more than one mental health provider/practitioner may participate in the CFT, there must be an identified mental health ICC coordinator that ensures participation by the child or youth, family or caregiver and significant others so that the child or youth's assessment and [client treatment] plan addresses the child or youth's needs and strengths in the context of the values and philosophy of the ICPM.

While the key service components of ICC are similar to TCM, the difference between ICC and the more traditional TCM is that ICC is intended for children and youth who are involved in multiple child-serving systems, have more intensive needs, and/or whose treatment requires cross-agency collaboration. ICC also differs from TCM in that there needs to be a CFT in place to provide feedback and recommendations to guide the provision of ICC services.

Service Components (Medi-Cal Manual)

ICC includes one or more of the following service components:

- Planning and Assessment of Strengths and Needs (Intensive Care Coordination)
- Re-Assessment of Strengths and Needs (Must be done at least every 90 days)
- Referral, Monitoring, and Follow-Up Activities
- Transition

Claiming (Mode, Service Function and Procedure Code Reference):

ICC is claimed under Mode 15. ICC includes the following Service Function Codes:

- 07 – Intensive Care Coordination

Refer to the Guide to Procedure Codes for a complete listing of procedure codes and disciplines which may be claimed as ICC. ICC shall be claimed in accord with Scope of Practice and the Guide to Procedure Codes.

Medi-Cal Lockouts (Medi-Cal Manual):

Medi-Cal lockouts for ICC are equivalent to TCM Medi-Cal lockouts (refer to the TCM section on Medi-Cal lockouts)

Additional Information (Medi-Cal Manual):

1. Service Settings/Limitations/Lockouts

When ICC is provided in a hospital, psychiatric health facility, community treatment facility, or psychiatric nursing facility, it will be used solely for the purpose of coordinating placement of the child or youth on discharge from those facilities. In this circumstance, ICC may be provided for the purpose of discharge planning, during the 30 calendar days immediately prior to the day of discharge, for a maximum of three, non-consecutive periods of 30 calendar days, or less, per continuous stay in the facility.

NOTE: Coordinating placement may include identifying and securing a placement, and setting up mental health services to support successful placement upon discharge from the hospital, psychiatric health facility or psychiatric nursing facility.

2. Additional reimbursement and documentation points

    - Participation in the CFT meeting is claimed as ICC.
    - Each participating practitioner in a CFT meeting may claim for the time he or she contributed to the CFT meeting, up to the length of the meeting.
    - Time claimed, which may include active listening time, must be supported by documentation showing what information was shared, and how it can/will be used in providing, planning, or coordinating services to the client (i.e., how the information discussed will impact the client plan).
    - Each participating provider in a CFT meeting may bill for the total number of minutes during which a client (or clients) with whom that practitioner has a client/practitioner relationship is discussed.

3. Intensive Care Coordination services require the development (and periodic revision) of a specific care plan within the progress note that is based on the information collected through the assessment and in accordance with the ICPM and reviewed within the CFT. The ICC care plan:

    - Specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual;

- Includes activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals;
- Identifies a course of action to respond to the assessed needs of the eligible individual;
- Includes development of a transition plan when a beneficiary has achieved the goals of the care plan. (DHCS IN 22-019 & 42 CFR 482.169(d))

(Refer also to Chapter 1 Needs Evaluation and Care Planning)

INTENSIVE HOME BASED SERVICES (IHBS)

Definition (Medi-Cal Manual):

IHBS are individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child's or youth's functioning. These interventions are aimed at helping the child/youth build skills for successful functioning in the home and community, as well as improving the family's ability to help the child/youth successfully function in the home and in the community. IHBS activities support the engagement and participation of the child or youth and his/her significant support persons. In addition, IHBS activities help the child or youth develop skills and achieve the goals and objectives of the plan. The difference between IHBS and more traditional outpatient SMHS is that IHBS is expected to be of significant intensity and will be predominantly delivered outside an office setting, and in the home, school, or community and whenever needed, including weekends and evenings.

IHBS includes, but is not limited to:

- Medically necessary skill-based interventions for the remediation of behaviors or improvement of symptoms, including but not limited to the implementation of a positive behavioral plan and/or modeling interventions for the child or youth's family and/or significant others to assist them in implementing the strategies;
- Development of functional skills to improve self-care, self-regulation, or other functional impairments by intervening to decrease or replace non-functional behavior that interferes with daily living tasks or the avoidance of exploitation by others;
- Development of skills or replacement behaviors that allow the child or youth to fully participate in the CFT and service plans including but not limited to the [client treatment] plan and/or child welfare service plan;
- Improvement of self-management of symptoms, including self-administration of medications as appropriate;
- Education of the child or youth and/or their family or caregiver(s) about, and how to manage the child or youth's mental health disorder or symptoms;
- Support of the development, maintenance and use of social networks including the use of natural and community resources;

- Support to address behaviors that interfere with the achievement of a stable and permanent family life;
- Support to address behaviors that interfere with seeking and maintaining a job;
- Support to address behaviors that interfere with a child or youth's success in achieving educational objectives in a community academic program; and
- Support to address behaviors that interfere with transitional independent living objectives such as seeking and maintaining housing and living independently.

Service Components (Medi-Cal Manual)

IHBS includes one or more of the following service components:

- Assessment
- Plan Development
- Rehabilitation

Claiming (Mode, Service Function and Procedure Code Reference):

IHBS is claimed under Mode 15. IHBS includes the following Service Function Codes:

- 57 – Intensive Home Based Service

Refer to the Guide to Procedure Codes for a complete listing of procedure codes and disciplines which may be claimed as IHBS. IHBS shall be claimed in accord with Scope of Practice and the Guide to Procedure Codes.

Medi-Cal Lockouts:

Medi-Cal lockouts for IHBS are equivalent to MHS Medi-Cal lockouts (refer to MHS section on Medi-Cal lockouts)

Additional Information (Medi-Cal Manual):

1. Authorization Requirements (DHCS Information Notice No.: 19-026)

   - ✓ IHBS services must be authorized by the Department prior to delivery and claiming.
   - ✓ Providers must request authorization by submitting the Supplemental IHBS Assessment form indicating the clinical need for the service and signed by an Authorized Mental Health Discipline (refer to Clinical Forms Bulletin 20-04) or a referral for Full Service Partnership or Wraparound;
   - ✓ For subsequent authorization requests, providers must request authorization by submitting an updated Supplemental IHBS Assessment form indicating the current clinical need for the service and signed by an Authorized Mental Health Discipline;

For Contracted providers, the documents must be submitted via the Provider Connect module of the Integrated Behavioral Health Information System (IBHIS), Service Request Tracking System (SRTS) or Wraparound Tracking System (WTS). For Directly-Operated

providers, the documents must be submitted via secure email to the CCR Division (ChildWelfareAuth@dmh.lacounty.gov).

Once the pre-authorization request is submitted, LACDMH will approve or deny the request within five (5) business days. If a provider determines, as indicated on the supplemental assessment form, that the standard timeframe could seriously jeopardize the client's life or health or ability to attain, maintain, or regain maximum functioning, LACDMH will make an expedited authorization decision within 72 hours. Once pre-authorized, services shall be authorized for a 12-month period. Providers must submit an additional request for authorization prior to the end of the pre-authorized period if the client is to continue with services.

An authorization is valid for any IHBS within a Legal Entity. A subsequent authorization request must be submitted when (1) an authorization expires and the client continues to need the service or (2) a different Legal Entity will be providing IHBS. A subsequent authorization is NOT needed when a client moves between provider/service locations within a Legal Entity.

2. Practitioners

IHBS are typically (but not only) provided by paraprofessionals under clinical supervision. Peers, including parent partners, may provide IHBS.

3. Service Settings

IHBS is intended to be provided to children and youth living and receiving services in the community.

IHBS may be provided in any setting where the child or youth is naturally located, including the home (biological, foster or adoptive) STRTPs, schools, recreational settings, child care centers, and other community settings. IHBS are available wherever and whenever needed including weekends and evenings.

4. Coordination with Other Specialty Mental Health Services

Certain services may be part of the child or youth's course of treatment, but may not be provided during the same hours of the day as IHBS services are being provided to the child or youth. These services include:

- Day Treatment Rehabilitative or Day Treatment Intensive
- Group Therapy
- Therapeutic Behavioral Services (TBS)

CHAPTER 3

Regulations and Requirements for Encounters

TYPES OF SERVICES

Mobile Crisis Services

MOBILE CRISIS

Definition (State Plan Amendment):

Community-based mobile crisis intervention services ("mobile crisis services") provide rapid response, individual assessment and community-based stabilization to Medi-Cal clients who are experiencing a mental health and/or substance use disorder ("behavioral health") crisis. Mobile crisis services are designed to provide relief to clients experiencing a behavioral health crisis, including through de-escalation and stabilization techniques; reduce the immediate risk of danger and subsequent harm; and avoid unnecessary emergency department care, psychiatric inpatient hospitalizations, and law enforcement involvement. Mobile crisis services include warm handoffs to appropriate settings and providers when the client requires additional stabilization and/or treatment services; coordination with and referrals to appropriate health, social and other services and supports, as needed, and short-term follow-up support to help ensure the crisis is resolved and the client is connected to ongoing care. Mobile crisis services are directed toward the client in crisis, but may include contact with a family member(s) or other significant support collateral(s) if the purpose of the collateral's participation is to assist the client in addressing their behavioral health crisis and restoring the client to the highest possible functional level.

Mobile crisis services are provided by a multidisciplinary mobile crisis team at the location where the individual is experiencing the behavioral health crisis. Locations may include, but are not limited to, the individual's home, school or workplace, on the street, or where an individual socializes. Mobile crisis services cannot be provided in hospitals or other facility settings. Mobile crisis services must be available to clients experiencing behavioral health crises 24 hours a day, 7 days a week, and 365 days a year.

Service Components (State Plan Amendment)

Mobile Crisis service components must include the following service components:

- Crisis assessment
- Mobile crisis response
- Crisis planning
- Facilitation of a warm handoff
- Referrals to ongoing supports
- Follow up check-ins

Claiming (Mode, Service Function and Procedure Code Reference):

Mobile Crisis Services are claimed as an encounter. Mobile Crisis Services include the following Service code: H2011HW

Refer to the Guide to Procedure Codes for a complete listing of procedure codes which may be claimed as Mobile Crisis Services. Mobile Crisis Services shall be claimed in accord with Scope of Practice and the Guide to Procedure Codes.

Medi-Cal Lockouts:

- Mobile crisis services cannot be provided to clients in a hospital or other facility setting.

Additional Information:

In addition to the Documentation Requirements noted in Chapter 1 and the beginning of Chapter 2, the following documentation and claiming rules apply:

- Mobile crisis assessments must be on the DMH approved crisis assessment form and include:
    - Causes leading to the crisis; including psychiatric, social, familial, legal factors and substance use;
    - Safety and risk for the beneficiary and others involved, including an explicit assessment of suicide risk, and access to any weapons or firearms;
    - Strengths and resources of the person experiencing the crisis, as well as those of family members and other natural supports;
    - Recent inpatient hospitalizations and/or any current relationship with a mental health provider;
    - Medications prescribed as well as information on the beneficiary's use of prescribed medication;
    - A rapid determination as to whether the crisis requires coordination with emergency medical services (EMS) or law enforcement; and
    - Medical history as it may relate to the crisis.

- There must be a written crisis safety plan on the DMH approved safety plan which shall include, but is not limited to:
    - A review of any immediate threats to the individual's or others' safety and well-being, such as accessible firearms or medications which could be used in a plan for self-harm or harm to others;
    - Conditions and factors that contribute to a crisis;
    - Alternative ways of responding to such conditions and factors;
    - Additional skill development and psychosocial education;
    - A psychiatric advanced directive;
    - Short and long-term prevention and strategies and resources the beneficiary can use to avert or address a future crisis, including harm reduction strategies.

    A copy of the crisis safety plan, if one is developed, shall be documented in the client's clinical record, and provided to the client and to their significant support collateral(s) if it is feasible and would benefit the client's treatment.
- Mobile crisis teams shall create a progress note that describes all service components delivered to the client, including any follow-up check-ins (including

whether or not the client could be contacted), referrals to ongoing supports, crisis planning (including whether or not the client was engaged in crisis planning), or facilitation of a warm handoff made as part of the mobile crisis services encounter.

- There may be times when the mobile crisis team is unable to engage the client in follow-up. Examples include, but are not limited to, the client is in inpatient treatment, otherwise incapacitated, unwilling to engage, or cannot be reached despite reasonably diligent efforts. The mobile crisis team shall document those instances where the client cannot be engaged for follow-up.

CHAPTER 4

Regulations and Requirements for Services Based on Blocks of Time (Mode 10)

SERVICE OVERVIEW & REIMBURSEMENT RULES
- General Rules

TYPES OF SERVICES
- Therapeutic Foster Care (TFCS)
- Crisis Stabilization (CS)
- Day Treatment Intensive (DTI)
- Day Rehabilitation (DR)
- Socialization Services
- Vocational Services

SERVICE OVERVIEW & REIMBURSEMENT RULES

GENERAL RULES

The reimbursable unit for these services is client time reported in the DMH electronic data system and claimed in hours, four-hour increments, half days or full days. These services are bundled services and are not claimed by individual staff. Service time is determined by client time NOT staff time.

THERAPEUTIC FOSTER CARE SERVICES (TFCS)

Definition (Medi-Cal Manual):

TFCS is a short-term, intensive, highly coordinated trauma-informed and individualized intervention, provided by a TFCS parent to a child or youth who has complex emotional and behavioral needs. TFCS is available for early and periodic screenings, Diagnosis and Treatment (EPSDT) benefit to children and youth, under the age of 21, who are Medi-Cal eligible and meet criteria to access specialty mental health services.

Intended Population

- Membership in the Katie A. class or subclass is not a prerequisite to receiving TFCS. Therefore, a child or youth who does not have an open child welfare services case, and is not in foster care or involved in the juvenile probation system, may be considered for TFCS, in an approved TFC resource home.
- TFCS is intended for children and youth who require intensive and frequent mental health support in a family environment.
- TFCS should not be the only SMHS that a child or youth receives. Children and youth receiving TFCS must receive ICC and other medically necessary SMHS, as set forth in the client plan.
- Similar to ICC and IHBS, there must be a CFT in place to guide the plan TFCS service provision.

TFCS are individualized strength-based interventions designed to ameliorate mental health conditions that interfere with a child's or youth's functioning. These interventions are aimed at: helping the child/youth build skills for successful functioning in the home and community, as well as improving the family's ability to help the child/youth successfully function in the home and in the community. TFCS activities support the engagement and participation of the child or youth and his/her significant support persons. In addition, TFCS activities help the child or youth develop skills and achieve the goals and objectives of the plan.

TFCS includes, but is not limited to:

- Medically necessary skill-based interventions for the remediation of behaviors or improvement of symptoms, including but not limited to the implementation of a

positive behavioral plan and/or modeling interventions for the child or youth's family and/or significant others to assist them in implementing the strategies;
- Development of functional skills to improve self-care, self-regulation, or other functional impairments by intervening to decrease or replace non-functional behavior that interferes with daily living tasks or the avoidance of exploitation by others;
- Development of skills or replacement behaviors that allow the child or youth to fully participate in the CFT and service plans including but not limited to the [client treatment] plan and/or child welfare service plan;
- Improvement of self-management of symptoms, including self-administration of medications as appropriate;
- Education of the child or youth and/or their family or caregiver(s) about, and how to manage the child or youth's mental health disorder or symptoms;
- Support of the development, maintenance and use of social networks including the use of natural and community resources;
- Support to address behaviors that interfere with the achievement of a stable and permanent family life;
- Support to address behaviors that interfere with seeking and maintaining a job;
- Support to address behaviors that interfere with a child or youth's success in achieving educational objectives in a community academic; and
- Support to address behaviors that interfere with transitional independent living objectives such as seeking and maintaining housing and living independently.

Service Components (Medi-Cal Manual)

TFCS includes one or more of the following service components:
- Plan Development (limited to when it is part of the CFT meeting)
- Rehabilitation
- Collateral

Claiming (Mode, Service Function and Procedure Code Reference):

TFCS is claimed under Mode 5. TFCS includes the following Service Function Codes:
- 94 – Therapeutic Foster Care

Refer to the Guide to Procedure Codes for a complete listing of procedure codes and disciplines which may be claimed as TFCS. TFCS shall be claimed in accord with Scope of Practice and the Guide to Procedure Codes.

Medi-Cal Lockouts:

Medi-Cal lockouts for TFCS are equivalent to MHS Medi-Cal lockouts (refer to MHS section on Medi-Cal lockouts)

Additional Information (Medi-Cal Manual):

1. Authorization Requirements (DHCS Information Notice No.: 19-026)

   - ✓ TFCS services must be authorized by the Department prior to delivery and claiming.
   - ✓ Providers must request authorization by submitting the Supplemental TFCS Assessment form indicating the clinical need for the service and signed by an Authorized Mental Health Discipline (refer to Clinical Forms Bulletin 20-04);
   - ✓ For subsequent authorization requests, providers must request authorization by submitting an updated Supplemental TFCS Assessment form indicating the current clinical need for the service and signed by an Authorized Mental Health Discipline.

   For Contracted providers, the documents must be submitted via the Provider Connect module of the Integrated Behavioral Health Information System (IBHIS).

   Once the pre-authorization request is submitted, LACDMH will approve or deny the request within five (5) business days. If a provider determines, as indicated on the supplemental assessment form, that the standard timeframe could seriously jeopardize the client's life or health or ability to attain, maintain, or regain maximum functioning, LACDMH will make an expedited authorization decision within 72 hours. Once pre-authorized, services shall be authorized for a 6-month period. Providers must submit an additional request for authorization prior to the end of the pre-authorized period if the client is to continue with services.

   An authorization is valid for any TFCS within a Legal Entity for a given Funding Source. A subsequent authorization request must be submitted when (1) an authorization expires and the client continues to need the service, (2) the client switches to a new Funding Source, or (3) a different Legal Entity will be providing TFCS. A subsequent authorization is NOT needed when a client moves between provider/service locations within a Legal Entity.

2. TFCS Parent/Providers

   To qualify as a Medi-Cal provider, the TFCS parent must be approved as a TFCS provider, and as a resource parent by the TFCS Agency.

   The TFCS parent must meet and comply with the following requirements related to his/her role as a TFCS parent(s):

   - The TFCS parent must be at least 21 years old and must meet California's Medicaid rehabilitation provider qualifications for "other qualified provider" (i.e., has a high school diploma or equivalent degree).
   - The TFCS parent must meet provider qualifications and other requirements regarding certification, oversight, etc., as established by the county MHP. The

process for a resource parent to become a TFCS parent will be determined by the TFCS Agency, in accordance with its contract with the MHP.

- The TFCS parent, including a relative caregiver, must be a resource family. Any additional processes regarding background checks and screenings will be determined by the MHP.
- The TFCS parent must have forty (40) hours of initial TFCS parent training provided by the TFCS Agency, which must be completed prior to the parent being eligible to provide services as a TFCS parent. An outline and agenda of the 40-hour training shall be provided to, and approved by, the MHP as a part of the contract.

The TFCS parent must complete twenty-four (24) hours of annual, ongoing training, provided by the TFCS Agency, related to providing TFCS. The ongoing, annual training includes an emphasis on skill development and application and SMHS knowledge acquisition, and can be provided in a variety of formats (video, readings, internet training, and webinars).

3. Service Setting

TFCS is primarily provided in the home where the child resides. However, TFCS may be provided in any setting where the child or youth is naturally located, including schools, recreational settings, and other community settings. TFCS will be provided daily, up to 7 days a week, including weekends, at any time of day, as medically necessary.

4. Supervision / Documentation Requirements

   a. The TFCS Parent will work under the supervision of the TFCS Agency, and under the direction of a Licensed Mental Health Professional (LMHP) or a Waivered or Registered Mental Health Professional (WRMP) employed by the TFCS agency.
   b. The TFCS parent(s) must write and sign a daily progress note for each day that TFCS is provided.
   c. The TFCS Agency's LMHP/WRMHP must review and co-sign each progress note, to indicate interventions are appropriate and that Medi-Cal documentation requirements are met.

5. Care Plan

TFCS requires a care plan that supports the goals of the service, is developed in accordance with the ICPM and is reviewed within the CFT (DHCS IN 22-019 & Medi-Cal Manual for ICC, IHBS, TCF Services for Medi-Cal Beneficiaries)

CRISIS STABILIZATION SERVICES (CS)

Definition (State Plan Amendment):

An unplanned, expedited service lasting less than 24 hours, to or on behalf of a client to address an urgent condition requiring immediate attention that cannot be adequately or safely addressed in a community setting. The goal of crisis stabilization is to avoid the need for inpatient services which, if the condition and symptoms are not treated, present an imminent threat to the client or others, or substantially increase the risk of the client becoming gravely disabled.

Service Components (State Plan Amendment)

Crisis Stabilization services include one or more of the following service components:

- Assessment
- Collateral
- Therapy
- Crisis Intervention
- Medication Support Services
- Referral

Frequency and Requirements of Documentation (State Contract)

For Crisis Stabilization, progress notes must be completed daily (one time per 23-hour period) and must include the elements identified in Chapter 1 Progress Notes.

Claiming (Mode, Service Function and Procedure Code Reference)

Crisis Stabilization services are claimed under Mode 10. Crisis Stabilization services include the following Service Function Codes:

- 24 – Crisis Stabilization (Emergency Room)
- 25 – Crisis Stabilization (Urgent Care Facility)

Refer to the Guide to Procedure Codes for a complete listing of procedure codes. Crisis Stabilization is a bundled service and is not claimed by individual staff. The Rendering Provider on the claim for Crisis Stabilization must be present on the day of service. The Rendering Provider may be the attending physician or staff writing the daily note (as long as all services described on the note are within scope of practice).

- Crisis Stabilization shall be reimbursed based on hours of time (CCR § 1840.322)

- Each one-hour block that the client receives Crisis Stabilization services shall be claimed (CCR § 1840.322).

- Partial blocks of time shall be rounded up or down to the nearest one-hour increment except that services provided during the first hour shall always be rounded up (CCR § 1840.322).

Note: Client time spent in the waiting room is not service time.

Medi-Cal Lockouts:

- Crisis Stabilization is not reimbursable on days when Psychiatric Inpatient Hospital Services, Psychiatric Health Facility Services or Psychiatric Nursing Facility Services are reimbursed, except on the day of admission to those services (State Plan Amendment). Note: The date of discharge is not reimbursable in the above facilities and thus Crisis Stabilization can be claimed on the day of admission <u>and</u> discharge from these facilities.

- Crisis Stabilization is a package program and no other Specialty Mental Health Services are reimbursable during the same time period this service is reimbursed, except for Targeted Case Management (CCR § 1840.368)

- The maximum number of hours claimable to Medi-Cal for Crisis Stabilization in a 24-hour period is 20 hours (State Plan Amendment).

Additional Requirements (State Plan Amendment unless otherwise noted):

In addition to the Documentation Requirements noted in Chapter 1, the following documentation and claiming rules apply:

Site Requirements

- Must be provided on site at a licensed 24-hour health care facility, at a hospital based outpatient program (services in a hospital based outpatient program are provided in accordance with 42 CFR 440.20), or at a provider site certified by the Department of Health Care Services to perform Crisis Stabilization.

- Medical backup services must be available either on site or by written contract or agreement with a general acute care hospital. Medical backup means immediate access within reasonable proximity to health care for medical emergencies.

Program Requirements

- Medications must be available on an as needed basis and the staffing pattern must reflect this availability.
- All clients receiving Crisis Stabilization must receive an assessment of their physical and mental health.

Staffing Requirements:

- A physician must be on call at all times for the provision of crisis stabilization services that must be provided by a physician.

- There shall be a minimum of one registered nurse, psychiatric technician, or licensed vocational nurse on site at all times clients are present. Other staff may be utilized by the program, according to need.

- At a minimum, there shall be a ratio of at least one licensed or waivered/registered mental health professional on site for each four clients receiving Crisis Stabilization services at the same time.

- If a client is evaluated as needing service activities that may only be provided by a specific type of licensed professional, such a person must be available.

- If Crisis Stabilization services are co-located with other specialty mental health services, staff providing Crisis Stabilization must be separate and distinct from staff providing other services (CCR § 1840.348).

- Persons included in required Crisis Stabilization ratios and minimums may not be counted toward meeting ratios and minimums for other services (CCR § 1840.348).

DAY TREATMENT INTENSIVE (DTI)

Definition (State Plan Amendment):

Day Treatment Intensive (DTI) is a structured, multi-disciplinary program which provides services to a distinct group of individuals. DTI is intended to provide an alternative to hospitalization, avoid placement in a more restrictive setting, or assist the client in living within a community setting. Services are available for at least three hours each day. DTI program is a program that lasts less than 24 hours each day. DTI may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the client. DTI services must have a clearly established site for services although all services need not be delivered at that site and some service components may be delivered through telehealth or telephone.

Service Components (State Plan Amendment):

Day Treatment Intensive services include one or more of the following service components:

- Assessment
- Treatment Planning
- Therapy
- Psychosocial Rehabilitation

Frequency and Requirements of Documentation:

For Day Treatment Intensive, there must be daily progress notes. In addition to the required elements identified in Chapter 1 Progress Notes, the daily notes for Day Treatment Intensive must include:

- The total number of minutes/hours the client actually attended the program (State Contract)

NOTE: While there is no formal State requirement to have sign-in sheets, sign-in sheets may be used to show evidence the client was present. If sign-in sheets are used, it is recommended that they minimally include:

- Date
- Client name
- Client/responsible adult signature or staff documentation for lack of signature
- Time of arrival
- Staff name and signature/credentials verifying attendance

The presence of sign-in sheets does not negate the requirement for total duration of client presence within the program to be documented on each daily progress note.

Claiming (Mode, Service Function and Procedure Code Reference)

Day Treatment Intensive services are claimed under Mode 10. Day Treatment Intensive services include the following Service Function Codes:

- 85 – Day Treatment Intensive (Full Day)
- 82 – Day Treatment Intensive (Half Day)

Refer to the Guide to Procedure Codes for a complete listing of procedure codes which may be claimed as Day Treatment Intensive. Day Treatment Intensive is a bundled service and is not claimed by individual staff. The Rendering Provider on the claim for Day Treatment Intensive must be present on that day of service.

- The billing unit for Day Treatment Intensive is client time, based on full or half day blocks of time (CCR §1840.318).

- Day Treatment Intensive services may only be claimed if the client is present at least 50% of scheduled hours of operation for that day. In cases where absences

are frequent, it is the provider's responsibility to ensure that there is re-evaluation of the client's need for the day treatment intensive program. (State Contract)

- A half day shall be claimed for each day in which the client receives face-to-face services in a program available four hours or less per day. Services must be available a minimum of three hours each day the program is open (CCR §1840.318).

  NOTE: The client must receive face-to-face services on any full or half day claimed but all service activities provided that day are not required to be face-to-face (State Contract).

  NOTE: Short breaks between activities are allowed. A lunch or dinner may also be appropriate depending on the program's schedule. However, these breaks shall not count towards the total hours of operation of the day program for purposes of determining minimum hours of service (State Contract).

- A full-day shall be claimed for each day in which the client receives face-to-face services in a program with services available more than four hours per day (CCR §1840.318).

- Medication Support Services that are provided within a Day Treatment Intensive program shall be billed separately from the Day Treatment Intensive programs (CCR §1840.326).

Medi-Cal Lockouts (CCR §1840.360)

- Day Treatment Intensive is not reimbursable 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. Note: The date of discharge is not reimbursable in the above facilities and thus DTI can be claimed on the day of admission and discharge from these facilities.

- Mental Health Services are not reimbursable when provided by Day Treatment Intensive staff during the same time period that Day Treatment Intensive services are being provided.

Additional Requirements

Authorization Requirements (State Contract):

- ✓ DTI services must be authorized by the Department prior to delivery and claiming.
- ✓ Providers must request authorization by submitting the Service Necessity Assessment (SNA) and Assessment forms indicating the clinical need for the service.

- ✓ For subsequent authorization requests, an updated SNA form indicating the current clinical need for the service must be submitted.
- ✓ Day Treatment Intensive services must be re-authorized at least every three months.

Site Requirements (CCR §1840.328 and State Plan Amendment):

- Day Treatment Intensive services shall have a clearly established site for services, although all services need not be delivered at that site (CCR §1840.328).

Staffing Requirements:

- For Day Treatment Intensive, at least one staff person whose scope of practice includes psychotherapy (State Contract).

- Program staff may be required to spend time on Day Treatment Intensive activities outside the hours of operation and therapeutic milieu. (State Contract).

- At least one staff person must be present and available to the group in the therapeutic milieu for all scheduled hours of operation (State Contract)

- If Day Treatment Intensive staff have other responsibilities (e.g., as staff of a group home, a school or other mental health program), the Day Treatment Intensive programs must maintain documentation of the scope of responsibilities for these staff and the specific times in which Day Treatment Intensive activities are being performed exclusive of other activities (State Contract).

- At a minimum there must be an average ratio of at least one person from the following list providing Day Treatment Intensive services to eight (8) clients in attendance during the period the program is open:

    - Physicians
    - Psychologists or related waivered/registered professionals
    - Licensed Clinical Social Workers or related waivered/registered professionals
    - Marriage and Family Therapists or related waivered/registered professionals
    - Registered Nurses
    - Licensed Vocational Nurses
    - Psychiatric Technicians
    - Occupational Therapists
    - Mental Health Rehabilitation Specialists (CCR §1840.350(a)).

NOTE: A mental health rehabilitation specialist is an individual who has a baccalaureate degree and four years of experience in a mental health setting as a specialist in the fields of physical

restoration, social adjustment, or vocational adjustment. Up to two years of graduate professional education may be substituted for the experience requirement on a year-for-year basis; up to two years of post-associate arts clinical experience may be substituted for the required educational experience, in addition to the requirement of four years' peeexperience in a mental health setting. (CCR, Title 9 CCR §630)

- Persons providing Day Treatment Intensive services who do not participate in the entire Day Treatment Intensive session, whether full-day or half-day, may be utilized according to program need, but shall only be included as part of the above ratio formula on a pro rata basis based on the percentage of time in which they participated in the session. The MHP shall ensure that there is a clear audit trail of the number and identity of the persons who provide Day Treatment Intensive services and function in other capacities (CCR §1840.350(b)).

- Persons providing services in Day Treatment Intensive programs serving more than twelve (12) clients shall include at least one person from two of the following groups:
    - Physicians
    - Psychologists or related waivered/registered professionals
    - Licensed Clinical Social Workers or related waivered/registered professionals
    - Marriage and Family Therapists or related waivered/registered professionals
    - Registered Nurses
    - Licensed Vocational Nurses
    - Psychiatric Technicians
    - Occupational Therapists
    - Mental Health Rehabilitation Specialists (CCR §1840.350(c)).

Program Requirements:

- In cases where absences are frequent, the need for the client to be in the Day Treatment Intensive program must be re-evaluated and appropriate action taken (State Contract).

- A written program description that describes the specific activities of each service and reflect each of the required components of the services (State Contract).

- An established protocol for responding to clients experiencing a mental health crisis. The protocol shall assure the availability of appropriately trained and qualified staff and include agreed upon procedures for addressing crisis situations. The protocol may include referrals for crisis intervention, crisis stabilization, or other specialty mental health services necessary to address the client's urgent or emergency psychiatric condition (crisis services). If the protocol includes referrals, the Day Treatment Intensive staff shall have the capacity to handle the crisis until the client is linked to an outside crisis service (State Contract).

- A detailed written weekly schedule identifying where and when the service components of the program will be provided and by whom shall be made available to clients and, as appropriate, to their families, caregivers, or significant support persons. The written weekly schedule shall specify the program staff, their qualifications, and the scope of their services (State Contract).

- At least one contact per month with a family member, caregiver or other significant support person identified by an adult client or one contact per month with the legally responsible adult for a client who is a minor. This contact may be face-to-face, by email, telephone or other method. Adult clients may decline this service component. The contact should focus on the role of the support person in supporting the client's community reintegration and shall occur outside the hours of operation and outside the therapeutic program for Day Treatment Intensive (State Contract).

DAY REHABILITATION

Definition (State Plan Amendment):

Day Rehabilitation is a structured program which provides services to a distinct group of individuals. Day Rehabilitation is intended to improve or restore personal independence and functioning necessary to live in the community or prevent deterioration of personal independence consistent with the principles of learning and development. Services are available for at least three hours each day. Day Rehabilitation is a program that lasts less than 24 hours each day. Day rehabilitation may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the beneficiary.

Service Components (State Plan Amendment):

Day Rehabilitation services may include one or more of the following service components:

- Assessment
- Treatment Planning
- Therapy
- Psychosocial Rehabilitation

Frequency and Requirements of Documentation

For Day Rehabilitation, there must be daily progress notes. In addition to the required elements identified in Chapter 1 Progress Notes, the daily notes for Day Rehabilitation must include:

- The total number of minutes/hours the client actually attended the program (State Contract)

NOTE: While there is no formal State requirement to have sign-in sheets, sign-in sheets may be used to show evidence the client was present. If sign-in sheets are used, it is recommended that they minimally include:

- Date
- Client name
- Client/responsible adult signature or staff documentation for lack of signature
- Time of arrival
- Staff name and signature/credentials verifying attendance

The presence of sign-in sheets does not negate the requirement for total duration of client presence within the program to be documented on each daily progress note.

NOTE: Staff completing the documentation must minimally meet the qualifications of a Mental Health Rehabilitation Specialist (MHRS).

Claiming (Mode, Service Function and Procedure Code Reference)

Day Rehabilitation services are claimed under Mode 10. Day Rehabilitation services include the following Service Function Codes:

- 98 – Day Rehabilitation (Full Day)
- 92 – Day Rehabilitation (Half Day)

Refer to the Guide to Procedure Codes for a complete listing of procedure codes and disciplines which may be claimed as Day Rehabilitation. Day Rehabilitation is a bundled service and is not claimed by individual staff. The Rendering Provider on the claim for Day Rehabilitation must be present on that day of service.

- The billing unit for Day Rehabilitation is client time, based on full or half days.

- Day Rehabilitation services may only be claimed if the client is present at least 50% of scheduled hours of operation for that day. In cases where absences are frequent, it is the provider's responsibility to ensure that there is re-evaluation of the client's need for the day treatment intensive program. (State Contract)

- A half day shall be claimed for each day in which the client receives face-to-face services in a program available four hours or less per day. Services must be available a minimum of three hours each day the program is open.

  NOTE: The client must receive face-to-face services on any full or half day claimed but all service activities provided that day are not required to be face-to-face.

  NOTE: Short breaks between activities are allowed. A lunch or dinner may also be appropriate depending on the program's schedule. However, these breaks shall not count towards the total hours of operation of the day program for purposes of determining minimum hours of service (State Contract).

- A full-day shall be claimed for each day in which the client receives face-to-face services in a program with services available more than four hours per day.

- Medication Support Services that are provided within a Day Rehabilitation program shall be billed separately from the Day Rehabilitation programs (CCR §1840.326)

Medi-Cal Lockouts (CCR §1840.360)

- Day Rehabilitation services are not reimbursable 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. Note: The date of discharge is not reimbursable in the above facilities and thus Day Rehabilitation can be claimed on the day of admission and discharge from these facilities.

- Mental Health Services are not reimbursable when provided by Day Rehabilitation staff during the same time period that Day Rehabilitation services are being provided.

Additional Requirements

Authorization Requirements (State Contract):

- ✓ Day Rehabilitation services must be authorized by the Department prior to delivery and claiming.
- ✓ Providers must request authorization by submitting the Service Necessity Assessment (SNA) and Assessment forms indicating the clinical need for the service.
- ✓ For subsequent authorization requests, an updated SNA form indicating the current clinical need for the service must be submitted.
- ✓ Day Rehabilitation services must be re-authorized at least every six months.

Staffing Requirements:

- Program staff may be required to spend time on Day Rehabilitation activities outside the hours of operation and therapeutic milieu (State Contract).

- At least one staff person must be present and available to the group in the therapeutic milieu for all scheduled hours of operation (State Contract).

- If Day Rehabilitation staff have other responsibilities (e.g., as staff of a group home, a school or other mental health program), the Day Rehabilitation programs must maintain documentation of the scope of responsibilities for these staff and the specific times in which Day Rehabilitation activities are being performed exclusive of other activities (State Contract).
- At a minimum there must be an average ratio of at least one person from the following list providing Day Rehabilitation services to ten (10) clients in attendance during the period the program is open:

    - Physicians
    - Psychologists or related waivered/registered professionals

- Licensed Clinical Social Workers or related waivered/registered professionals
- Marriage and Family Therapists or related waivered/registered professionals
- Registered Nurses
- Licensed Vocational Nurses
- Psychiatric Technicians
- Occupational Therapists
- Mental Health Rehabilitation Specialists (CCR §1840.352(a)).

NOTE: A mental health rehabilitation specialist is an individual who has a baccalaureate degree and four years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment. Up to two years of graduate professional education may be substituted for the experience requirement on a year-for-year basis; up to two years of post-associate arts clinical experience may be substituted for the required educational experience, in addition to the requirement of four years of experience in a mental health setting. (CCR, Title 9 CCR §630)

- Persons providing Day Rehabilitation services who do not participate in the entire Day Rehabilitation session, whether full-day or half-day, may be utilized according to program need, but shall only be included as part of the above ratio formula on a pro rata basis based on the percentage of time in which they participated in the session. The MHP shall ensure that there is a clear audit trail of the number and identity of the persons who provide Day Rehabilitation services and function in other capacities (CCR §1840.352(b)).

- Persons providing services in Day Rehabilitation programs serving more than twelve (12) clients shall include at least one person from two of the following groups:
  - Physicians
  - Psychologists or related waivered/registered professionals
  - Licensed Clinical Social Workers or related waivered/registered professionals
  - Marriage and Family Therapists or related waivered/registered professionals
  - Registered Nurses
  - Licensed Vocational Nurses
  - Psychiatric Technicians
  - Occupational Therapists
  - Mental Health Rehabilitation Specialists (CCR §1840.352(c)).

Program Requirements:

- In cases where absences are frequent, the need for the client to be in the Day Rehabilitation program must be re-evaluated and appropriate action taken (State Contract).

- A written program description that describes the specific activities of each service and reflects each of the required components of the services (State Contract).

- At least one contact per month with a family member, caregiver or other significant support person identified by an adult client or one contact per month with the legally responsible adult for a client who is a minor. This contact may be face-to-face, by email, telephone or other method. Adult clients may decline this service component. The contact should focus on the role of the support person in supporting the client's community reintegration and shall occur outside the hours of operation and outside the therapeutic program for Day Rehabilitation (State Contract).

SOCIALIZATION DAY SERVICES

Socialization Day Services (CCR §542)

Services designed to provide activities for persons who require structured support and the opportunity to develop the skills necessary to move toward more independent functioning. The services in this program include outings, recreational activities, cultural events, linkages to community resources, and other rehabilitation efforts. Services are provided to persons who might otherwise lose contact with a social or treatment system.

Frequency and Requirements of Documentation

For Socialization Day services, progress notes must be completed weekly. In addition to the elements identified in Chapter 1 Progress Notes, the weekly note for Socialization Day Services must include:

- Time period covered by the note
- Dates of service within the time period covered by the note
- The total number of blocks of time delivered for each date of service
- The activities in which the client participated
- A summary describing what was attempted and/or accomplished toward the client's goal(s) by the client and service staff
- The current functional level of the client
- The current functional impairment of the client

Claiming (Mode, Service Function and Procedure Code Reference)

Socialization Day services are claimed under Mode 10. Socialization Day services include the following Service Function Code:

- 41 – Socialization Day Service

Refer to the Guide to Procedure Codes for a complete listing of procedure codes and disciplines which may be claimed as Socialization Day Services. Socialization Day Services is a bundled service and is not claimed by individual staff. The Rendering Provider on the claim for Socialization Day Services must be present on the day of service.

- The billing unit for Socialization Day Services is client time, based on four hour blocks of time.

Medi-Cal Lockouts

- Socialization Day Services may never be claimed to Medi-Cal.

Additional Requirements

- Less than or equal to four hours is one block of time. Greater than four hours and up to eight hours is two blocks of time. Greater than eight hours and up to twelve hours is three blocks of time.
- No more than three blocks of time may be claimed in a day.
- Costs for documentation are included in the rate for these services and shall not be separately billed.

VOCATIONAL DAY SERVICES

Vocational Day Services

This bundled service is designed to encourage and facilitate individual motivation and focus upon realistic and attainable vocational goals. To the extent possible, the intent of these services is to maximize individual client involvement in skill seeking enhancement with an ultimate goal of self-support. These vocational services shall be bundled into a milieu program for chronically and persistently mentally ill clients who are unable to participate in competitive employment.

The program stresses development of sound work habits, skills, and social functioning for marginally productive persons who ultimately may be placed in work situations ranging from sheltered work environments to part or full-time competitive employment.

Frequency and Requirements of Documentation

For Vocational Day Services, progress notes must be completed weekly. In addition to the elements identified in Chapter 1 Progress Notes, the weekly progress notes for Vocational Day Services must include:

- Time period covered by the note
- Dates of service within the time period covered by the note
- The total number of blocks of time delivered for each date of service
- The activities in which the client participated
- A summary describing what was attempted and/or accomplished toward the client's goal(s) by the client and service staff
- The current functional level of the client
- The current functional impairment of the client

Claiming (Mode, Service Function and Procedure Code Reference)

Vocational Day services are claimed under Mode 10. Vocational Day services include the following Service Function Codes:

- 31 – Vocational Day Service

Refer to the Guide to Procedure Codes for a complete listing of procedure codes and disciplines which may be claimed as Vocational Day Services. Vocational Day Services is a bundled service and is not claimed by individual staff. The Rendering Provider on the claim for Vocational Day Services must be present on the day of service.

- The billing unit for Vocational Day Services is client time, based on four hour blocks of time.

Medi-Cal Lockouts

- Vocational Day Services may never be claimed to Medi-Cal.

Additional Requirements

- Less than or equal to four hours is one block of time. Greater than four hours and up to eight hours is two blocks of time. Greater than eight hours and up to twelve hours is three blocks of time.

- No more than three blocks of time may be claimed in a day.

- Costs for documentation are included in the rate for these services and shall not be separately billed.

CHAPTER 5

Regulations and Requirements for Services Based on Calendar Days (Mode 5)

GENERAL RULES

ADULT RESIDENTIAL TREATMENT SERVICES
(Transitional and Long-Term)

CRISIS RESIDENTIAL TREATMENT SERVICES

PSYCHIATRIC HEALTH FACILITY

PSYCHIATRIC INPATIENT HOSPITAL SERVICES

SERVICE OVERVIEW & REIMBURSEMENT RULES

GENERAL RULES

The reimbursable unit for these services is client time reported in the DMH electronic data system and claimed based on calendar days. These services are bundled services and are not claimed by individual staff. Service time is determined by client time NOT staff time.

Claiming Rules (CCR §1840.320):

- A day shall be billed for each calendar day in which the client receives face-to-face services and the client has been admitted to the program. Services may not be billed for the days the client is not present.
- Board and Care costs are not included in the claiming rate.
- The day of admission may be billed but not the day of discharge.

ADULT RESIDENTIAL TREATMENT SERVICES

Definition (State Plan Amendment)

Recovery focused rehabilitative services, provided in a non-institutional, residential setting, for clients who would be at risk of hospitalization or other institutional placement if they were not in the residential treatment program.

The service is available 24 hours a day, seven days a week and structured day and evening services are available all seven days.

Adult residential treatment services must have a clearly established site for services although all services need not be delivered at that site and some service components may be delivered through telehealth or telephone.

In an adult residential treatment facility, structured day and evening services are available seven days a week.

Service Components (State Plan Amendment)

Adult residential treatment services include one or more of the following service components:

- Assessment
- Treatment Planning
- Therapy

- Psychosocial Rehabilitation

Frequency and Requirements of Documentation (State Contract)

For Adult Residential Treatment, progress notes must be completed daily and must include the elements identified in Chapter 1 Progress Notes.

In addition, Adult Residential Treatment programs must meet the requirements identified in CCR, Title 9, Division 1, Chapter 3, Article 3.5 §532.2.

Claiming (Mode, Service Function and Procedure Code Reference)

Adult residential treatment services are claimed under Mode 5. Adult residential treatment services include the following Service Function Codes:

- 65 – Adult Residential (Transitional)
- 70 – Adult Residential (Long Term)

Refer to the Guide to Procedure Codes for a complete listing of procedure codes. Adult residential treatment is a bundled service and is not claimed by individual staff. The Rendering Provider on the claim for Adult Residential Treatment must have participated in the delivery of the service and/or clinically overseen the service. A Rendering Provider may be the staff writing the weekly note (so long as all services described on the note are within scope of practice).

- Medication Support Services shall be billed separately from a residential program (CCR §1840.326(b)).

- Services shall not be claimable unless there is face-to-face contact between the client and a treatment staff person of the facility on the day of service and the client has been admitted to the program (CCR §1840.332 (a))

Medi-Cal Lockouts (State Plan Amendment unless otherwise noted)

- Adult residential treatment services are not reimbursable on days when the following services are reimbursed, except for day of admission to adult residential treatment services: mental health services, day treatment intensive, day rehabilitation, crisis residential treatment services, crisis intervention, crisis stabilization, psychiatric inpatient hospital services, psychiatric health facility services, or psychiatric nursing facility services.

- Providers may not allocate the same staff's time under the two cost centers of Adult Residential and Mental Health Services for the same period of time. (CCR §1840.362(b))

Additional Requirements (State Plan Amendment unless otherwise noted)

- Adult residential treatment services are not provided in an institution for mental disease (IMD)

Program Requirements

- In an adult residential treatment facility, structured day and evening services are available seven days a week. Services include:

    A. Individual and group counseling;
    B. Crisis intervention such as counseling focusing on immediate problem solving in response to a critical emotional incident to augment the client's usual coping mechanisms;
    C. Family counseling with significant support persons, when indicated in the client's treatment/rehabilitation plan;
    D. The development of community support systems for clients to maximize their utilization of non-mental health community resources;
    E. Counseling focused on reducing mental health symptoms and functional impairments to assist clients to maximize their ability to obtain and retain pre-vocational employment;
    F. Assisting clients to develop self-advocacy skills through observation, coaching, and modeling;
    G. An activity program that encourages socialization within the program and general community, and which links the client to resources which are available after leaving the program; and,
    H. Use of the residential environment to assist clients in the acquisition, testing, and/or refinement of community living and interpersonal skills.
    NOTE: See also CCR §532 Service Requirements

Site Requirements

- Adult residential treatment services must have a clearly established site for services although all services do not need to be delivered at the site

- Programs providing Adult Residential Treatment Services must be certified as a Social Rehabilitation Program by the Department [State DHCS] as either a Transitional Residential Treatment Program or a Long Term Residential Treatment Program in accordance with Chapter 3, Division 1, of [CCR] Title 9. Facility capacity must be limited to a maximum of 16 beds. (CCR §1840.332 (b))

- In addition to Social Rehabilitation Program certification, programs which provide Adult Residential Treatment Services must be licensed as a Social Rehabilitation Facility or Community Care Facility by the State Department of Social Services in accordance with Chapters 1 and 2, Division 6, of [CCR] Title 22 or authorized to operate as a Mental Health Rehabilitation Center by the Department [State DHCS]

in accordance with Chapter 3.5, Division 1, of [CCR] Title 9, beginning with Section 51000. (CCR §1840.332 (c)).

Staffing Requirements

- Staffing ratios and qualifications in Crisis Residential Treatment Services shall be consistent with CCR, Title 9, §531. (CCR §1840.354(a))

- To be certified as a Transitional Residential Treatment Program, a program shall ensure that: A greater number of staff shall be present during times when there are greater numbers of clients in programmed activities. Staff schedules shall be determined by the program based on the number of clients in the program during specific hours of the day, level of care provided by the program, and the range of services provided within the facility. At least one staff member shall be present at any time there are clients at the facility. There shall be a staffing ratio of at least one (1) full-time equivalent direct service staff for each 2.5 clients served. All scheduled hours in the facility shall be considered part of this required full-time equivalent staffing ratio (CCR §531(b) (2)).

- To be certified as a Long-Term Residential Treatment Program, a program shall ensure: Scheduling of staff which provides for the maximum number of staff to be present during the times when clients are engaged in structured activities. At least one direct service staff shall be on the premises 24-hours a day, seven (7) days per week. Additional staff, including part-time or consulting services staff, shall be on duty during program hours to provide specialized services and structured evening services. When only one staff member is on the premises there shall be staff on call who can be contacted by telephone if an additional staff person is needed, and can be at the facility and on duty within 60 minutes after being contacted. There shall be a staffing ratio of at least one (1) full-time equivalent direct service staff member for each 2.8 clients served CCR §531(c) (2)).

- There shall be a clear audit trail of the number and identify of the persons who provide Adult Residential Treatment Services and function in other capacities (CCR §1840.354(b))

CRISIS RESIDENTIAL TREATMENT SERVICES

Definition (State Plan Amendment)

Therapeutic or rehabilitative services provided in a non-institutional residential setting which provides a structured program (short term – 3 months or less) as an alternative to hospitalization for clients experiencing an acute psychiatric episode or crisis who do not have medical complications requiring nursing care. The service is available 24 hours a

day, seven days a week and structured day and evening services are available all seven days.

Crisis residential treatment services must have a clearly established site for services although all services need not be delivered at that site and some service components may be delivered through telehealth or telephone. Services will not be claimable unless the beneficiary has been admitted to the program and there is face-to face contact between the beneficiary and a treatment staff person of the facility on the day of service.

In a crisis residential treatment facility, structured day and evening services are available seven days a week.

Service Components (State Plan Amendment)

Crisis Residential Treatment services include one or more of the following service components:

- Assessment
- Treatment Planning
- Therapy
- Psychosocial Rehabilitation
- Crisis Intervention

Frequency and Requirements of Documentation (State Contract)

For Crisis Residential Treatment, progress notes must be completed daily and must include the elements identified in Chapter 1 Progress Notes.

In addition, Adult Residential Treatment programs must meet the requirements identified in CCR Title 9, Division 1, Chapter 3, Article 3.5 §532.2.

Claiming (Mode, Service Function and Procedure Code Reference)

Crisis Residential Treatment services are claimed under Mode 5. Crisis Residential Treatment Services include the following Service Function Code:

- 43 – Crisis Residential

Refer to the Guide to Procedure Codes for a complete listing of procedure codes. Crisis residential treatment is a bundled service and is not claimed by individual staff. The Rendering Provider on the claim for Crisis Residential Treatment must have participated in the delivery of the service and/or clinically overseen the service. A Rendering Provider may be the staff writing the daily note (so long as all services described on the note are within scope of practice).

- Medication Support Services shall be billed separately from a residential program (CCR §1840.326(b))

- Services shall not be claimable unless there is face-to-face contact between the client and a treatment staff person of the facility on the day of service (CCR §1840.334(a))

Medi-Cal Lockouts (State Plan Amendment)

- Crisis residential treatment services are not reimbursable on days when the following services are reimbursed, except for day of admission to crisis residential treatment services: mental health services, day treatment intensive, day rehabilitation, adult residential treatment services, crisis intervention, crisis stabilization, psychiatric inpatient hospital services, psychiatric health facility services, or psychiatric nursing facility services. Note: The date of discharge is not reimbursable in the above facilities and thus crisis residential service can be claimed on the day of admission <u>and</u> discharge from these facilities.

Additional Requirements (State Plan Amendment unless otherwise noted)

- Crisis residential treatment services are not provided in an institution for mental disease (IMD)

Program Requirements

- In a crisis residential treatment facility, structured day and evening services are available seven days a week. Services include:

    A. Individual and group counseling;
    B. Crisis intervention such as counseling focusing on immediate problem solving in response to a critical emotional incident to augment the client's usual coping mechanisms;
    C. Planned activities that develop and enhance skills directed towards achieving client plan goals;
    D. Family counseling with significant support persons, when indicated in the client's treatment/rehabilitation plan;
    E. The development of community support systems for clients to maximize their utilization of non-mental health community resources;
    F. Counseling focused on reducing mental health symptoms and functional impairments to assist clients to maximize their ability to obtain and retain pre-vocational employment;
    G. Assisting clients to develop self-advocacy skills through observation, coaching, and modeling;
    H. An activity program that encourages socialization within the program and general community, and which links the client to resources which are available after leaving the program; and,

I. Use of the residential environment to assist clients in the acquisition, testing, and/or refinement of community living and interpersonal skills.
NOTE: See also CCR §532 Service Requirements

- Programs shall have written procedures for accessing emergency psychiatric and health services on a 24-hour basis (CCR §1840.334(b)).

Site Requirements

- Programs providing Crisis Residential Treatment Services shall be certified as a Social Rehabilitation Program (Short-Term Crisis Residential Treatment Program) by the Department [State DHCS] in accordance with Chapter 3, Division 1, of [CCR] Title 9. Facility capacity must be limited to a maximum of 16 beds. (CCR §1840.334(c))

- In addition to Social Rehabilitation Program certification, programs providing Crisis Residential Treatment Services shall be licensed as a Social Rehabilitation Facility or Community Care Facility by the State Department of Social Services or authorized to operate as a Mental Health Rehabilitation Center by the Department in accordance with Chapter 3.5, Division 1, of [CCR] Title 9, beginning with Section 51000. (CCR §1840.334(d))

Staffing Requirements

- Staffing ratios and qualifications in Crisis Residential Treatment Services shall be consistent with CCR, Title 9, CCR §531. (CCR §1840.356(a))

- To be certified as a Short-Term Crisis Residential Treatment Program, a program shall ensure: Scheduling of staff which provides for at least two (2) staff members to be on duty 24 hours a day, seven (7) days per week. If program design results in some clients not being in the facility during specific hours of the day, scheduling adjustments may be made so that coverage is consistent with and related to the number and needs of clients in the facility. During the nighttime hours, when clients are sleeping, only one of the two on duty staff members need be awake, providing the program does not accept admissions at that time. There shall be a staffing ratio of at least one (1) full-time equivalent direct service staff for each 1.6 clients served. (CCR §531(a)(2))

- There shall be a clear audit trail of the number and identify of the persons who provide Crisis Residential Treatment services and function in other capacities (CCR §1840.356(b))

PSYCHIATRIC HEALTH FACILITY

Definition (State Plan Amendment unless otherwise notes)

Therapeutic and/or rehabilitative services provided in a psychiatric health facility licensed by the Department of Health Care Services. Psychiatric health facilities are licensed to provide acute inpatient psychiatric treatment to individuals with major mental disorders. Psychiatric health facility services may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the client.

Services are provided in a psychiatric health facility under a multidisciplinary model and some service components may be delivered through telehealth or telephone. Psychiatric health facilities may only admit and treat patients who have no physical illness or injury that would require treatment beyond what ordinarily could be treated on an outpatient basis.

"Psychiatric Health Facility" means a facility licensed by the Department [State DHCS] under the provisions of Chapter 9, Division 5 of [CCR] Title 22, beginning with Section 77001. For the purposes of this chapter, psychiatric health facilities that have been certified by the State Department of Health Services as Medi-Cal providers of inpatient hospital services will be governed by the provisions applicable to hospitals and psychiatric inpatient hospital services, except when specifically indicated in text. (CCR §1810.236)

Service Components (State Plan Amendment)

Psychiatric Health Facility services include one or more of the following service components:

- Assessment
- Treatment Planning
- Therapy
- Psychosocial Rehabilitation
- Crisis Intervention

Frequency and Requirements of Documentation (CCR §77141 and §77073)

For Psychiatric Health Facility services, each client's clinical record shall consist of at least the following:

1. Admission and discharge record identification data including, but not limited to the following:
    a. Name
    b. Address on admission
    c. Patient identification number
    d. Social security number
    e. Date of birth
    f. Sex
    g. Marital status
    h. Legal status
    i. Religion (option on part of client)

    j. Date of admission
    k. Date of discharge
    l. Name, address and telephone number of person or agency responsible for client
    m. Initial diagnostic impression
    n. Discharge or final diagnosis
    o. Disposition, including aftercare arrangements, plus a copy of the aftercare plan prepared pursuant to section 1284, Health and Safety Code, if the client was placed in the facility under a county Short-Doyle plan
2. Mental status
3. Medical history and physical examination
4. Dated and signed observations and progress notes recorded as often as the client's condition warrants by the person responsible for the care of the client
5. Any necessary legal authorization for admission
6. Consultation reports
7. Medication treatment and diet orders
8. Social service evaluation, if applicable
9. Psychological evaluation, if applicable
10. Dated and signed client care notes including, but not limited to, the following:
    a. Concise and accurate records of nursing care provided
    b. Records of pertinent nursing observations of the client and the client's response to treatment
    c. The reasons for the use of and the response of the client to PRN medication administered and justification for withholding scheduled medications
    d. Record of type of restraint, including time of application and removal as outlined in section 77103
11. Rehabilitation evaluation, if applicable
12. Interdisciplinary treatment plan
13. Progress notes including the client's response to medication and treatment rendered and observation(s) of client by all members of treatment team providing services to the client
14. Medication records including name, dosage and time of administration of medications and treatments given. The route of administration and site of injection shall be recorded if other than by oral administration.
15. Treatment records including group and individual psychotherapy, occupational therapy, recreational or other therapeutic activities provided
16. Vital sign sheet
17. Consent forms as required, signed by client or person responsible for client
18. All dental records, if applicable
19. Reports of all laboratory tests ordered
20. Reports of all cardiographic or encephalographic tests performed
21. Reports of all X-ray examinations ordered
22. All reports of special studies ordered
23. Acknowledgment in writing of client's rights, as required in section 77099, signed by the client or person responsible for client
24. Denial of client rights documentation

25. A discharge summary prepared by the admitting practitioner which shall briefly recapitulate the significant findings and events of the client's treatment, his/her condition on discharge and the recommendation and arrangement for future care

A. A written interdisciplinary treatment plan shall be developed and implemented by the interdisciplinary treatment team for each client as soon as possible after admission but no longer than 72 hours following the client's admission, Saturdays, Sundays and holidays excepted.
B. The interdisciplinary treatment plan shall include as a minimum:
    1. A statement of the client's physical and mental condition, including all diagnoses
    2. Specific goals of treatment with interventions and actions, and observable, measurable objectives
    3. Methods to be utilized, the frequency for conducting each treatment method and the person(s) or discipline(s) responsible for each treatment method
C. The interdisciplinary treatment plan shall be reviewed and modified as frequently as the client's condition warrants, but at least weekly

Claiming (Mode, Service Function and Procedure Code Reference)

Psychiatric Health Facility services are claimed under Mode 5. Psychiatric Health Facility services include the following Service Function Code:

- 20 – Psychiatric Health Facility

Refer to the Guide to Procedure Codes for a complete listing of procedure codes. Psychiatric Health Facility services are a bundled service and are not claimed by individual staff. The Rendering Provider on the claim for Psychiatric Health Facility services must be present on the day of service. The Rendering Provider may be the staff writing the daily note (so long as all services described on the note are within scope of practice).

- Services shall not be claimable unless there is face-to-face contact between the client and a treatment staff person of the facility on the day of service and the client has been admitted to the program. (CCR §1840.340(a))

Medi-Cal Lockouts (State Plan Amendment)

- Psychiatric health facility services are not reimbursable on days when any of the following services are reimbursed, except for the day of admission to psychiatric health facility services: adult residential treatment services, crisis residential treatment services, crisis intervention, day treatment intensive, day rehabilitation, psychiatric inpatient hospital services, medication support services, mental health services, crisis stabilization, or psychiatric nursing facility services.

Additional Requirements (State Plan Amendment unless otherwise noted)

- No Federal Financial Participation is available for psychiatric health facility services furnished in facilities with more than 16 beds for services provided to beneficiaries who are 21 years of age and older and under 65 years of age.

Site Requirements

- Psychiatric Health Facility services shall have a clearly established certified site for services. (CCR §1840.340(a))

- Programs providing Psychiatric Health Facility Services must be licensed as a Psychiatric Health Facility by the Department [State DHCS] (CCR §1840.340(b))

Program Requirements

- Programs shall have written procedures for accessing emergency health services on a 24-hour basis. (CCR §1840.340(c))

- Notwithstanding any other provisions of this Chapter, the medical necessity criteria that apply to psychiatric health facility services are the medical necessity criteria of Section 1820.205. (CCR §1830.245(a)) – See Medical Necessity Criteria under Psychiatric Inpatient Hospital Services section.

Staffing Requirements

- Staffing ratios in Psychiatric Health Facility services shall be consistent with CCR Title 22, Section 77061 (CCR §1840.358(a)).

- Staffing ratios must adhere to CCR Title 22, Division 5, Article 3, §77061 which includes:
  (h) Each facility shall meet the following full-time equivalent staff to census ratio, in a 24-hour period:
    1. See grid below

Inpatient Census	**1-10**	**11-20**	**21-30**	**31-40**	**41-50**	**51-60**	**61-70**	**71-80**	**81-90**	**91-100**
Psychiatrist or Clinical Psychologist or Clinical Social Worker or Marriage, Family & Child Counselor	1	2	3	4	5	6	7	8	9	10
Registered Nurse or Licensed Vocational Nurse or Psychiatric Technician	4	5	6	8	10	12	14	16	18	20
Mental Health Worker	3	5	8	10	13	15	18	20	23	25
Total Staff	**8**	**12**	**17**	**22**	**28**	**33**	**39**	**44**	**50**	**55**

2. For facilities in excess of 100 beds, staffing shall be provided in the ratios as in (1) above.
3. A registered nurse shall be employed 40 hours per week.
4. There shall be a registered nurse, a licensed vocational nurse, or a psychiatric technician awake and on duty in the facility at all times.

(i) The required staffing ratio shall be calculated based upon the inpatient census and shall provide services only to psychiatric health facility clients.

(j) Regardless of minimum staffing required in subsection (h)(1) above, the facility shall employ professional and other staff on all shifts in the number and with the qualifications to provide necessary services for those patients admitted for care.

PSYCHIATRIC INPATIENT HOSPITAL SERVICES

Definitions (CCR)

"Psychiatric Inpatient Hospital Services" means both acute psychiatric inpatient hospital services and administrative day services provided in a hospital (CCR §1810.238).

Additional relevant definitions:

"Hospital" means an institution that meets the requirements of Title 22, Section 51207, and has been certified by the State Department of Health Services as a Medi-Cal provider of inpatient hospital services. Hospital includes [but is not limited to] acute psychiatric hospitals as defined in Section 1250(b) of the Health and Safety Code, and psychiatric health facilities certified by the State Department of Health Services as Medi-Cal providers of inpatient hospital services (CCR §1810.219).

"Short-Doyle/Medi-Cal Hospital" means a hospital that submits claims for Medi-Cal psychiatric inpatient hospital services through the [State Department of Health Care Services] to the State Department of Health Services and not to the fiscal intermediary (CCR §1810.246).

"Acute Psychiatric Inpatient Hospital Services" means those services provided by a hospital to clients for whom the facilities, services and equipment described in Section 1810.350 are medically necessary for diagnosis or treatment of a mental disorder in accordance with Section 1820.205 (CCR §1810.201).

"Administrative Day Services" means psychiatric inpatient hospital services provided to a client who has been admitted to the hospital for acute psychiatric inpatient hospital services, and the client's stay at the hospital must be continued beyond the client's need for acute psychiatric inpatient hospital services due to a temporary lack of residential placement options at non-acute residential treatment facilities that meet the needs of the client (CCR §1810.202).

“Continued Stay Services” means psychiatric inpatient hospital services for clients that occur after admission (CCR §1820.200).

“Emergency Admission” means an admission of a client to a hospital due to an emergency psychiatric condition for psychiatric inpatient hospital services (CCR §1820.200).

“Planned Admission” means an admission of a client to a hospital with a contract with an MHP for the purpose of providing medically necessary treatment that cannot be provided in another setting or a lower level of care and is not an emergency admission (CCR §1820.200).

“Utilization Review Committee” means a committee that reviews services provided to determine appropriateness for psychiatric inpatient hospital services, identifies problems with quality of care, and meets the requirements of Title 42, CFR, Chapter IV, Subchapter C, Part 456, Subpart D (CCR §1820.200).

“Emergency Psychiatric Condition” means a condition that meets the criteria in Section 1820.205 when the client with the condition, due to a mental disorder, is a current danger to self or others, or immediately unable to provide for or utilize, food, shelter or clothing, and requires psychiatric inpatient hospital or psychiatric health facility services (CCR §1810.216).

“Routine Hospital Services” means bed, board and all medical, nursing and other support services usually provided to an inpatient by a hospital. Routine hospital services do not include hospital-based ancillary services, psychiatric or other physician services, or psychologist services (CCR §1810.244).

“Hospital-Based Ancillary Services” means services, which include but are not limited to prescription drugs, laboratory services, x-ray, electroconvulsive therapy (ECT) and magnetic resonance imaging (MRI), that are received by a client admitted to a hospital, other than routine hospital services (CCR §1810.220).

“Psychiatric Inpatient Hospital Professional Services” means specialty mental health services provided to a client by a licensed mental health professional with hospital admitting privileges while the client is in a hospital receiving psychiatric inpatient hospital services. Psychiatric inpatient hospital professional services do not include all specialty mental health services that may be provided in an inpatient setting. Psychiatric inpatient hospital professional services include only those services provided for the purpose of evaluating and managing the mental disorder that resulted in the need for psychiatric inpatient hospital services. Psychiatric inpatient hospital services do not include routine hospital services or hospital-based ancillary services (CCR §1810.237.1).

Covered Services (CCR §1810.350)

Psychiatric Inpatient Hospital Services for a Short-Doyle/Medi-Cal hospital shall include:

1. Routine hospital services
2. All hospital-based ancillary services, and
3. Psychiatric inpatient hospital professional services

Medical Necessity Criteria (CCR §1820.205)

(A) For Medi-Cal reimbursement for an admission to a hospital for psychiatric inpatient hospital services, the client shall meet the following criteria:

1. One of the following diagnoses in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, DSM-IV*T *(1994)*, published by the American Psychiatric Association:
    A. Pervasive Developmental Disorders
    B. Disruptive Behavior and Attention Deficit Disorders
    C. Feeding and Eating Disorders of Infancy or Early Childhood
    D. Tic Disorders
    E. Elimination Disorders
    F. Other Disorders of Infancy, Childhood, or Adolescence
    G. Cognitive Disorders (only Dementias with Delusions, or Depressed Mood)
    H. Substance Induced Disorders, only with Psychotic, Mood, or Anxiety Disorder
    I. Schizophrenia and Other Psychotic Disorders
    J. Mood Disorders
    K. Anxiety Disorders
    L. Somatoform Disorders
    M. Dissociative Disorders
    N. Eating Disorders
    O. Intermittent Explosive Disorder
    P. Pyromania
    Q. Adjustment Disorders
    R. Personality Disorders
2. Meet both of the following criteria:
    A. Cannot be safely treated at a lower level of care, except that a client who can be safely treated with crisis residential treatment services or psychiatric health facility services for an acute psychiatric episode shall be considered to have met this criterion; and
    B. Requires psychiatric inpatient hospital services, as the result of a mental disorder, due to the indications in either (1) or (2) below:
        1) Has symptoms or behaviors due to a mental disorder that (one of the following):
            a. Represent a current danger to self or others, or significant property destruction.
            b. Prevent the client from providing for, or utilizing, food, clothing or shelter.
            c. Present a severe risk to the client's physical health.
            d. Represent a recent, significant deterioration in ability to function.

2) Require admission for one of the following:
    a. Further psychiatric evaluation.
    b. Medication treatment.
    c. Other treatment that can reasonably be provided only if the client is hospitalized.

(B) Continued stay services in a hospital shall only be reimbursed when a client experiences one of the following:

1. Continued presence of indications that meet the medical necessity criteria as specified in 1, 2A and 2B above.
2. Serious adverse reaction to medications, procedures or therapies requiring continued hospitalization.
3. Presence of new indications that meet medical necessity criteria specified in 1, 2A and 2B above.
4. Need for continued medical evaluation or treatment that can only be provided if the client remains in a hospital.

Administrative Day Criteria (CCR §1820.220(l)(5))

Requests for MHP payment authorization for administrative day services shall be approved by an MHP when the following conditions are met in addition to requirements for timeliness of notification and any mandatory requirements of the contract negotiated between the hospital and the MHP:

A. During the hospital stay, a client previously has met medical necessity criteria for reimbursement of acute psychiatric inpatient hospital services.
B. There is no appropriate, non-acute residential treatment facility in a reasonable geographic area and a hospital documents contacts with a minimum of five appropriate, non-acute residential treatment facilities per week subject to the following requirements:
    1. Point of Authorization staff may waive the requirements of five contacts per week if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options for the beneficiary. In no case shall there be less than one contact per week.
    2. The lack of placement options at appropriate, non-acute residential treatment facilities and the contacts made at appropriate facilities shall be documented to include but not be limited to:
        a. The status of the placement option.
        b. Date of the contact.
        c. Signature of the person making the contact.
C. The qualifying non-acute residential treatment placements in accord with Cal. Code Regs. Tit. 9, §1820.220(l)(5)(B) are held by the DMH Quality, Outcomes and Training Division. The qualifying non-acute residential treatment placements under Exemption from Cal. Code Regs.Tit. 9, §1820.220(l)(5)(B) are held by the DMH Intensive Care Division.
D. If a qualifying placement requires conservatorship as a prerequisite to admission, then Administrative Days may be claimed for a patient awaiting conservatorship to the placement.

E. An MHP may submit a request to the Department [DHCS] for approval to use an alternative to the procedures described in this section (see Exemption from CCR §1820.220, next section).

Exemption from CCR §1820.220 (State Contract)

The LACDMH may exempt hospitals from the requirements of CCR §1820.220 noted above for clients who are inpatients of the hospital receiving administrative day services if the hospital refers the client for consideration under the discharge process administered by the LACDMH's Intensive Care Division (ICD) and ICD accepts the client for placement consideration under the process.

Frequency and Requirements of Documentation

The requirements for reimbursement for each day of continued stay services in a psychiatric inpatient hospital are referenced in section B under Medical Necessity Criteria (CCR §1820.205) above. In addition, there must be a written Plan of Care as indicated below.

Written Plan of Care (CFR 42 §456.180; State Contract)

A. Before admission to a mental hospital or before authorization for payment, the attending physician or staff physician must establish a written plan of care for each applicant or client.
B. The plan of care must include:
    1. Diagnoses, symptoms, complaints, and complications indicating the need for admission;
    2. A description of the functional level of the client;
    3. Objectives – specific observable and/or specific quantifiable goal/treatment objectives related to the client's mental health needs and functional impairments resulting from the qualifying mental health diagnosis/diagnoses;
    4. Descriptions of the types of interventions/modalities, including a detailed description of the interventions to be provided;
    5. A proposed frequency and duration for each of the interventions;
    6. Interventions which are consistent with the qualifying diagnoses;
    7. Any orders for:
        i. Medications;
        ii. Treatments;
        iii. Restorative and rehabilitative services;
        iv. Activities;
        v. Therapies;
        vi. Social services;
        vii. Diet; and
        viii. Special procedures recommended for the health and safety of the client;

8. Plans for continuing care, including review and modification to the plan of care; and
9. Plans for discharge.
10. Documentation of the client's degree of participation in and agreement with the plan.
11. Documentation of the physician's establishment of the plan.

C. The attending or staff physician and other personnel involved in the client's care must review each plan of care at least every 90 days.

Claiming (Mode, Service Function and Procedure Code Reference)

Psychiatric Inpatient Hospital services are claimed under Mode 5. Psychiatric Inpatient Hospital Services include the following Service Function Codes:

- 14 – Local Psychiatric Hospital, Acute Days, age 21 or under
- 15 – Local Psychiatric Hospital, Acute Days, age 22 and over
- 19 – Local Psychiatric Hospital, Administrative Days, all ages

Refer to the Guide to Procedure Codes for a complete listing of procedure codes. Psychiatric Inpatient Hospital Services are a bundled service and are not claimed by individual staff.

Medi-Cal Lockouts

- Psychiatric Inpatient Hospital Services are subject to the IMD Exclusion (see Chapter 1, Medi-Cal Reimbursement Rules), except as provided in CCR §1840.210.

- The MHP may claim Federal Financial Participation (FFP) for psychiatric inpatient hospital services in a psychiatric health facility that is larger than 16 beds and is certified by the State Department of Health Services as a Medi-Cal provider of inpatient hospital services or an acute psychiatric hospital that is larger than 16 beds <u>only under</u> the following conditions (CCR §1840.210(a)):
    - The client is 65 years of age or older, or
    - The client is under 21 years of age, or
    - The client was receiving such services prior to his/her twenty-first birthday and the services are rendered without interruption until no longer required or his/her twenty-second birthday, whichever is earlier.

- The following services are not reimbursable on days when psychiatric inpatient hospital services are reimbursed, except for the day of admission to psychiatric inpatient hospital services (CCR §1840.215(a)):
    1) Adult Residential Treatment Services,
    2) Crisis Residential Treatment Services,
    3) Crisis Intervention,
    4) Day Treatment Intensive,

5) Day Rehabilitation,
6) Psychiatric Nursing Facility Services (except as provided in CCR §1840.215 Subsection (b)),
7) Crisis Stabilization, and
8) Psychiatric Health Facility Services.

- Psychiatric Nursing Facility Services may be claimed for the same day as psychiatric inpatient hospital services, if the client has exercised the bed hold option provided by Title 22, Sections 72520, 73504, 76506, and 76709.1, subject to the limitations of Title 22, Section 51535.1.

- When psychiatric inpatient hospital services are provided in a Short-Doyle/Medi-Cal hospital, in addition to the services listed in (CCR §1840.215(a)), psychiatrist services, psychologist services, mental health services, and medication support services are included in the per diem rate and not separately reimbursable, except for the day of admission.

- See the previous section on Targeted Case Management Services for Medi-Cal lockouts related to TCM.

Medical Care Evaluation (MCE) Studies for Psychiatric Inpatient Hospitals

- **Purpose & General Description** (42 C.F.R. §§ 456.241, 456.242)
  a) The purpose of MCE studies is to promote the most effective and efficient use of available health facilities and services consistent with patient needs and professionally recognized standards of health care.
  b) MCE studies –
     1) Emphasize identification and analysis of patterns of patient care; and
     2) Suggest appropriate changes needed to maintain consistently high-quality patient care and effective and efficient use of services

- **Content of MCE Studies** (42 C.F.R. § 456.243)
  Each MCE Study must –
  a) Identify and analyze medical or administrative factors related to the psychiatric hospital's patient care;
  b) Include analysis of at least the following:
     1) Admissions
     2) Durations of stay
     3) Ancillary services furnished, including drugs and biologicals
     4) Professional services performed in the hospital; and
  c) If indicated, contain recommendations for change beneficial to patients, staff, the hospital, and the community

- **Number of studies required to be performed** (42 C.F.R. § 456.245)
    a) The psychiatric hospital must, at least, have one study in progress at any time and complete one study each calendar year.
    Note: while it is not required to submit to DHCS an "in-progress" MCE, DHCS assumes that there is a study being conducted currently.

- **MCE Study Format Template**
    1. Identify a problem or issue which impacts the quality of patient care within the context of the psychiatric inpatient unit
    2. Gather preliminary (pre-intervention) data (i.e., established baseline)
    3. Employ an intervention that is hypothesized to increase the quality of patient care as it relates to the identified problem
    4. Measure the possible impact the intervention had on the identified problem (post-intervention data)
    5. Analyze the post-intervention data to determine if there was or was not a significant effect, and
    6. Present results with a discussion of how the findings impact the quality of patient care (positive, negative, neutral) and of the possible limitations of the study.

- **Teaming Process with MHP (LACDMH)**
    1. Prior to implementing a new MCE study, the psychiatric inpatient hospital will complete #1 and #2 of the above MCE Study Format Template and send it to the MHP.
    2. The MHP will schedule a virtual meeting with the appropriate psychiatric hospital staff to provide feedback and confirm agreement for hospital staff to move forward with the proposed MCE.

- **Additional Requirements**

FFP for Short-Doyle/Medi-Cal hospitals shall be claimed through the Short-Doyle/Medi-Cal system in accordance with CCR §1840.110 (CCR §1840.205(a)).

CHAPTER 6

Regulations and Requirements for Short-Doyle/Medi-Cal Provider Certification

OVERVIEW

In order for Los Angeles County Department of Mental Health (LACDMH) directly-operated and contract providers to provide Specialty Mental Health Services (SMHS) to Medi-Cal beneficiaries, and be reimbursed for those services, the providers must first be Medi-Cal certified by the California Department of Health Care Services (DHCS) or its designee, the LACDMH. In order for the providers to continue to provide SMHS, and be reimbursed for those services, each provider must be recertified at a minimum of once every three (3) years. Each provider must remain in compliance with certification requirements at all times.

GENERAL REQUIREMENTS

LACDMH shall certify the providers that contract with LACDMH to provide covered services in accordance with Cal. Code Regs., tit. 9, §1810.435 (State Contract).

LACDMH may allow a contract provider to begin delivering covered services to beneficiaries at a site subject to on-site review prior to the date of the on-site review, provided the site is operational and has any required fire clearances. The earliest date the provider may begin delivering covered services at a site subject to on-site review is the latest of these three (3) dates: 1) the date the provider's request for certification is received by DHCS in accordance with LACDMH's certification procedures; 2) the date the site was operational; or 3) the date a required fire clearance was obtained. LACDMH shall complete any required on-site review of a provider's sites within six months of the date the provider begins delivering covered services to clients at the site (State Contract).

LACDMH may allow a contract provider to continue delivering covered services to clients at a site subject to on-site review as part of the recertification process prior to the date of the on-site review, provided the site is operational and has any required fire clearances (State Contract).

LACDMH shall monitor the performance of its contract providers on an ongoing basis for compliance with the terms of the State Contract and shall subject the contract provider's performance to periodic formal review, at a minimum in accordance with the recertification requirements. If LACDMH identifies deficiencies or areas for improvement, LACDMH and the contract provider shall take corrective action (State Contract).

In selecting providers with which to contract, LACDMH shall require that each provider (CCR §1810.435):

1. Possess the necessary license to operate.
2. Provide for appropriate supervision of staff.
3. Have as Head of Service a licensed mental health professional (LACDMH).
4. Possess appropriate liability insurance.

5. Maintain a safe facility.
6. Store and dispense medications in compliance with all pertinent State and federal standards.
7. Maintain client records in a manner that meets State and federal standards.
8. Meet LACDMH's Quality Management Program standards and requirements;
    a. Establish and maintain a written Quality Management Program that describes its quality assurance, quality improvement and utilization review structure, process, decisions, actions and monitoring, in accordance with LACDMH Quality Improvement Program Policy No. 1100.01, to ensure that the quality and appropriateness of care delivered to clients of the mental health system meets or exceeds the established County, State, and federal service standards and complies with the standards set by the DHCS through the Performance Contract and/or Mental Health Plan Agreement.
    b. The Quality Management Program shall be consistent with the LACDMH Quality Improvement Program Policy No. 1100.01 including the Department's Quality Improvement Work Plan and participation in Service Area Quality Assurance and Quality Improvement Committee meetings.
    c. The Quality Management Program shall be consistent with the LACDMH Cultural Competency Plan.
    d. The Quality Management Program shall be consistent with the LACDMH Quality Assurance requirements for Contract Providers as outlined in Policy No. 401.03.
9. Have accounting and fiscal practices that are sufficient to comply with its obligations pursuant to CCR 1840.105.
10. Meet any additional requirements established by LACDMH as part of a credentialing or other evaluation process.

CERTIFICATION PROCESS

The following steps must be completed in order to certify a Medi-Cal provider:

1. For Contract Providers, a contract between LACDMH and the Provider is approved and signed.
2. The LACDMH Contract Management and Monitoring Division (CMMD) Lead Manager or liaison (LDC) completes a Provider File Adjustment Request (PFAR) and sends it to the Department's Chief Information Office Bureau (CIOB) and Quality, Outcomes & Training Division/Quality Assurance Unit/Medi-Cal Certification Team (Certification).
3. Certification contacts the Provider and informs the Provider of all applicable Medi-Cal certification requirements. The Provider must;
    a. Have a National Provider Identifier (NPI) number in the National Plan and Provider Enumeration System (NPPES) that will be uniquely associated with only one active Provider Number.
    b. Ensure that their NPPES "Other Name" and "Primary Practice Address" are accurate.

c. Obtain a Provider Number from DHCS, requested by CIOB as part of the PFAR process.
d. Obtain a current Fire Clearance (defined by DHCS as within 12 months of the certification on-site review). The Fire Clearance must be verified as valid by Certification.
e. Submit a Head of Service License (HOS). The HOS must be on the Provider's official staff roster as an employee and meet LACDMH requirements.

4. Certification and the Provider coordinate the date/time of the on-site review.
5. Certification conducts the on-site review using the most current DHCS Certification Protocol and LACDMH Checklist to ensure the Provider meets all program and contractual requirements. Any items found out of compliance must be corrected and verified by Certification. When the Provider meets all certification requirements, the on-site review is usually completed in one day. The duration of the on-site review may vary depending on the size of the Provider and the complexity of the Modes of Service to be certified. The need for a Plan of Correction will cause a delay in the submission of documents to DHCS and may require an additional on-site review.
6. Certification submits documents to DHCS for approval. The State may take up to four weeks to complete the approval process.
7. When Certification receives approval from DHCS, Certification informs the LDC and CIOB of the approval and provides them the supporting documents.
8. CIOB enters the information into the LACDMH electronic system.
9. Certification mails the Consolidated Medi-Cal Certification Approval Letter to the Provider. The Letter serves as official notice of the approval for certification of the Provider.
10. The permanent Medi-Cal Provider Identification Number (PIN) is sent directly to the Provider by DHCS. The PIN is required in order for the Provider to check for the Medi-Cal eligibility of potential clients. A temporary PIN may be used while waiting for the permanent PIN.
11. The Provider may submit claims back to the Medi-Cal Activation/Effective Date of certification.
12. The Activation/Effective Date of certification is the date designated as such on the Consolidated Medi-Cal Certification Approval Letter.

ON-SITE REVIEW

The on-site review required by Cal. Code Regs., tit. 9, §1810.435(d), as a part of the certification process, shall be made of any site owned, leased, or operated by the provider and used to deliver covered services to beneficiaries (State Contract).

An onsite review is required for public school and satellite sites. Satellite sites are subject to the same certification provisions as all other sites. (LACDMH)

NOTE: "Satellite site" means a site owned, leased or operated by an organizational provider at which specialty mental health services are delivered to beneficiaries fewer than 20 hours per week, or, if located at a multiagency site at which specialty mental health services are delivered by no more than two employees or contractors of the provider (State Contract).

In certain situations, the on-site review of a provider must be performed by DHCS. Otherwise, the on-site review may be [and currently is] conducted by LACDMH. County-owned and operated providers requiring on-site review by DHCS include, but are not limited to (DMH Letter No. 10-04):

1. Initial (New) Provider Certifications
2. Activation of one or more of the following Modes of Service/Service Functions (MS/SF):
    a. Medication Support (15/60)
        i. Activation of "Prescription Only" Med Support (15/60) (not for dispensing, administering and/or storing of medications including samples) does not require an on-site review.

    NOTE: Medication Support is service function 62. See Chapter 2 on Medication Support Services.

    b. Crisis Stabilization (10/20, 10/25)
    c. Day Treatment (10/81, 10/85, 10/91, 10/95)
3. County-owned and operated providers that have a change of address
4. Re-certification of:
    a. Crisis Stabilization (10/20, 10/25)
    b. Day Treatment (10/81, 10/85, 10/91, 10/95)
    c. Providers located within Juvenile Detention Facilities

County-owned and operated providers for whom on-site review by DHCS is not required are those County-owned and operated providers who are currently certified for any of the following Modes of Service/Service Functions:

a. Case Management/Brokerage** (15/01)
   NOTE: Case Management/Brokerage is Targeted Case Management and is service function 01 and 07. See Chapter 2 on Targeted Case Management and ICC.
b. Mental Health Services*** (15/30)
   NOTE: Mental Health Services is service function 34, 42, 52 and 57. See Chapter 2 on Mental Health Services and IHBS.
c. Therapeutic Behavioral Services (15/58)
d. Medication Support (15/60*)
e. Crisis Intervention (15/70)

LACDMH may elect [and does elect] to complete the provider recertification(s) prior to the triennial provider(s) recertification due date. However, the triennial recertification date is established with each subsequent recertification which means that the next triennial due date will be three years from the date LACDMH established as the date of recertification.

LACDMH may continue to use the [State] Provider Site Re/Certification Protocol form when certifying and re-certifying its contract providers.

LACDMH and/or DHCS shall each verify through an on-site review that (State Contract):

1. The provider possesses the necessary license to operate, if applicable, and any required certification.
2. The space owned, leased or operated by the provider and used for services or staff meets local fire codes.
3. The physical plant of any site owned, leased, or operated by the provider and used for services or staff is clean, sanitary, and in good repair.
4. The provider establishes and implements maintenance policies for any site owned, leased, or operated by the provider and used for services or staff to ensure the safety and well-being of clients and staff.
5. The provider has a current administrative manual which includes: personnel policies and procedures, general operating procedures, service delivery policies, any required state or federal notices (DRA), and procedures for reporting unusual occurrences relating to health and safety issues.
6. The provider maintains client records in a manner that meets the requirements of LACDMH, the requirements of the State Contract, and applicable state and federal standards.
7. The provider has sufficient staff to allow LACDMH to claim federal financial participation (FFP) for the services that the provider delivers to clients, as described in Cal. Code Regs., tit. 9, §1840.344 through §1840.358, as appropriate and applicable.
8. The provider has written procedures for referring individuals to a psychiatrist when necessary, or to a physician, if a psychiatrist is not available.
9. The provider's head of services, as defined in Cal. Code Regs., tit. 9, §622 through §630, is a licensed mental health professional (LACDMH).
10. For providers that provide or store medications, the provider stores and dispenses medications in compliance with all pertinent state and federal standards. In particular:
    a. All drugs obtained by prescription are labeled in compliance with federal and state laws. Prescription labels are altered only by persons legally authorized to do so.
    b. Drugs intended for external use only and food stuffs are stored separately from drugs intended for internal use.
    c. All drugs are stored at proper temperatures: room temperature drugs at 59-86 degrees Fahrenheit and refrigerated drugs at 36-46 degrees Fahrenheit.
    d. Drugs are stored in a locked area with access limited to those medical personnel authorized to prescribe, dispense or administer medication.
    e. Drugs are not retained after the expiration date. Intramuscular multi-dose vials are dated and initialed when opened.
    f. A drug log is maintained to ensure the provider disposes of expired, contaminated, deteriorated and abandoned drugs in a manner consistent with state and federal laws.
    g. Policies and procedures are in place for dispensing, administering and storing medications.

11. For providers that provide day treatment intensive or day rehabilitation, the provider has a written description of the day treatment intensive and/or day rehabilitation program that complies with the State Contract.
12. When on-site review of a provider is required, LACDMH or DHCS, as applicable, shall conduct an on-site review at least once every three years. Additional certification reviews of organizational providers may be conducted by LACDMH or DHCS, as applicable, at its discretion, if:
    a. The provider makes major staffing changes.
    b. The provider makes organizational and/or corporate structure changes (example: conversion to non-profit status).
    c. The provider adds day treatment or medication support services when medications are administered or dispensed from the provider site.
    d. There are significant changes in the physical plant of the provider site (some physical plant changes could require a new fire clearance).
    e. There is a change of ownership or location.
    f. There are complaints regarding the provider.
    g. There are unusual events, accidents, or injuries requiring medical treatment for clients, staff or members of the community.

CERTIFICATION CHECKLIST AND PROTOCOL

The on-site review is conducted using the LACDMH Medi-Cal Certification/Re-Certification Checklist for directly-operated or contract providers, as applicable, and the DHCS S/D Provider Certification and Re-Certification Protocol.

1. The LACDMH Checklist includes the following items:
    a. Guide for Pertinent Information
        - Provider name and number, address, contact information, Head of Service, fire clearance date, catchment areas, days and hours of operation, source of referrals, ethnicity of population served, staffing patterns/disciplines, languages spoken by staff, information on school-based sites/satellite sites and DTI/DR programs

    b. Documents for Medi-Cal Certification/Re-Certification
        - General Provider Information, Brochures and Notices
        - Fire Clearance
        - Physical Plant Information
        - Protected Health Information (PHI) Policies
        - Head of Service (HOS) and Staffing
        - Medication Support Service Information (if medications are stored and/or dispensed)
    c. LACDMH Policies and Procedures Related to Medi-Cal Certification/Re-Certification
        - Departmental Administration/Operations

- Compliance and Ethics
- Client Services/Patient's Rights
- Clinic Operations
- Quality of Care/Quality Assurance/Clinical Documentation
- Human Resources
- Risk Management

d. Physical Plant Inspection Checklist
e. Additional Information/Resources
f. Staff Roster Form

2. The DHCS Certification Protocol includes the following items:
   a. Posted Brochures and Notices
      - Client brochure, provider list, grievance/appeal/expedited appeal forms
   b. Fire Safety Inspection
   c. Physical Plant
      - Cleanliness, structural integrity, safety, PHI security
   d. Policies and Procedures
      - PHI, emergency evacuation, personnel, general operation, maintenance, service delivery, unusual occurrences reporting, referral to psychiatrist or physician, HOS
   e. Head of Service and Licensed Staff
      - Note: LACDMH requires HOS to be licensed
   f. Crisis Stabilization Services
      - Physician availability, staffing requirements, medical backup, medication availability, assessment procedures, use of nurse practitioners and physician assistants, duration of services, 5150 designation, population served, acceptance of police transports, furniture, seclusion and restraint, cleanliness and safety, patient monitoring, medical and psychiatric emergencies, non-English speaking patients, patient/staff interaction, family visitation, discharge dispositions, dietary facilities
   g. Medication Support Services
      - Storage of medications on-site, labeling, medication logs, auditing supplies of controlled substances, medication disposal
   h. Day Treatment Intensive/Day Rehabilitation
      - Service components, written weekly schedule, program description, crisis protocol, hours of operation, client attendance, documentation standards, staffing
   i. Plan of Correction (if required)
      - Date issued, due, received and approved
   j. Approval
      - New certification activation approval date
      - Re-certification approval date

APPENDIX

APPENDIX I
Definitions: Criteria to Access SMHS (BHIN 21-073)

Homelessness: The beneficiary meets the definition established in section 11434a of the federal McKinney-Vento Homeless Assistance Act. Available at: https://nche.ed.gov/mckinney-vento-definition/. Full text of the Act is available here: http://uscode.house.gov/view.xhtml?path=/prelim@title42/chapter119/subchapter6/partB&edition=prelim Specifically, this includes (A) individuals who lack a fixed, regular, and adequate nighttime residence (within the meaning of section 103(a)(1) of the Act); and (B) includes (i) children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; or are abandoned in hospitals; (ii) children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (within the meaning of section 103(a)(2)(C)); (iii) children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and (iv) migratory children (as such term is defined in section 1309 of the Elementary and Secondary Education Act of 1965) who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses (i) through (iii).

Involvement in child welfare: The beneficiary has an open child welfare services case, or the beneficiary is determined by a child welfare services agency to be at imminent risk of entering foster care but able to safely remain in their home or kinship placement with the provision of services under a prevention plan, or the beneficiary is a child whose adoption or guardianship occurred through the child welfare system. A child has an open child welfare services case if: a) the child is in foster care or in out of home care, including both court-ordered and by voluntary agreement; or b) the child has a family maintenance case (pre-placement or post-reunification), including both court-ordered and by voluntary agreement. A child can have involvement in child welfare whether the child remains in the home or is placed out of the home.

Juvenile Justice Involvement: The beneficiary (1) has ever been detained or committed to a juvenile justice facility, or (2) is currently under supervision by the juvenile delinquency court and/or a juvenile probation agency. Beneficiaries who have ever been in custody and held involuntarily through operation of law enforcement authorities in a juvenile justice facility, including youth correctional institutions, juvenile detention facilities, juvenile justice centers, and other settings such as boot camps, ranches, and forestry/conservation camps, are included in the “juvenile justice involvement” definition. Beneficiaries on probation, who have been released home or detained/placed in foster care pending or post-adjudication, under probation or court supervision, participating in juvenile drug court or other diversion programs, and who are otherwise under supervision by the juvenile delinquency court and/or a juvenile probation agency also meet the “juvenile justice involvement” criteria.