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

for

SPECIALTY MENTAL HEALTH SERVICES

under

THE REHABILITATION OPTION

and

TARGETED CASE MANAGEMENT SERVICES

Children/Adolescents,
Transitional Age Youth (TAY),
Adults and Older Adults

Effective: July 1, 1993
Updated: July 12, 2021

****

LOS ANGELES COUNTY
LOCAL MENTAL HEALTH PLAN

Jonathan E. Sherin, M.D., Ph.D., 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

MEDI-CAL MEDICAL NECESSITY – THE CLINICAL LOOP

ASSESSMENT

NEEDS EVALUATION

CLIENT TREATMENT PLAN

PROGRESS NOTES

SERVICE COMPONENTS

GENERAL SERVICE AND REIMBURSEMENT RULES

O V E R V I E W

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) (formerly State Department of Mental Health) 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 treatment planning and implementation. The goal is to help clients take charge of their lives through informed decision-making. Services are based on the client's long-term goals/desired result(s) from mental health services concerning his/her own life and his/her diagnosis, functional impairment(s), symptoms, disabilities, life conditions and rehabilitation readiness. Services are focused on achieving specific, measurable objectives to support the client in accomplishing his/her desired results. 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.

Key Points Applicable to One or More Mode of Services

- **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**.

- **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).

- **All covered services must be provided under the direction** (CCR §1840.314) **of an Authorized Mental Health Discipline (AMHD) and as designated by the Program Manager:** Examples of service direction include, but are not limited to:
  - Being the person providing the service;
  - Acting as a clinical team leader;
  - Direct or functional supervision of service delivery; or
  - Approval of Client Care Plans.

  The person providing direction is not required to be physically present at the service site to exercise direction (State DMH Letter No.: 01-02).

  Authorized Mental Health Disciplines (AMHD) include the following disciplines:
  - Licensed Psychiatrist/Physician, (MD/DO);
  - Certified Nurse Practitioner (NP), registered Clinical Nurse Specialist (CNS), Registered Nurse (RN);
  - Licensed or waivered Psychologist (PhD/PsyD);
  - Licensed Clinical Social Worker (LCSW) or registered Masters in Social Work (Associate Clinical Social Worker - ASW) or out-of-state licensed-ready waivered Masters in Social Work;
  - Licensed Marriage and Family Therapist (LMFT) or registered Marriage and Family Therapist or out-of-state licensed-ready waivered Marriage and Family Therapist;
  - Licensed Professional Clinical Counselor (LPCC) or registered Professional Clinical Counselor (PCC) and
  - All students of these disciplines with co-signature signifying final responsibility lies with the co-signer (a formal written agreement between the school and the Legal Entity must be in place for staff to be considered a student).

- **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).

- **The time required for documentation and travel must be linked to the delivery of the reimbursable service** (CCR §1840.316). The time required for documentation and travel is reimbursable when the documentation or travel is a component of a reimbursable service whether or not the time is on the same day as the reimbursable service. If documentation or travel occurs on a day other than the date of the service, the Progress Note must still be dated the date of the service and must include the documentation and/or travel time on that date. There must be a reference in the note of when the documentation/travel time occurred if on a different date than the date of service. While, on occasion, this may result in the claimed hours on a particular day exceeding the actual hours worked, this is not an audit issue as long as the total time claimed accurately reflects the service/travel/documentation time provided and when it occurred.

- **As with all Medi-Cal services, travel should be individualized to the needs of the client.** Travel time should be reasonable and appropriate given normal circumstances. If travel time is extensive, the note should document distance traveled to support the claim. For the purpose of this guidance, each provider/practitioner is responsible for making the determination as to what constitutes reasonable and appropriate travel time in each specific situation according to their own best judgment.

- **Travel time may be claimed from a provider site to an off-site location, from the practitioner's residence to an off-site location, or between two or more off-site locations.** When claiming for travel between off-site locations, the travel time claimed should be associated to the service at the location being traveled to, not travelled from. (Medi-Cal Billing Manual; DHCS Information Notice No.: 17-040)

- **Travel time between provider sites (i.e. two billing providers) or from a practitioner's residence to a provider site is not reimbursable.** (Medi-Cal Billing Manual) A "provider site" is defined as a site with a provider number, this includes affiliated satellite sites and school sites.

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

- **Missed Appointments** (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, this time or travel time to a missed appointment cannot be claimed when no services are provided. If record review is done in preparation for an appointment that is subsequently missed or cancelled, it is considered a service and therefore is reimbursable (DHCS Information Notice No.: 17-040).

- **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.**

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 assessment, client treatment plan or initial progress note 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.

- **All entries in the client record shall include** (State Contract):
  - The date of service;
  - The signature of the person providing the service (or electronic equivalent), the person's type of professional degree, licensure, or job title; and the relevant identification number (if applicable);

NOTE: Only the signature (or electronic equivalent) of the person writing the progress note is required (DHCS Information Notice No.: 17-040).

  - The date the documentation was entered in the client record.

NOTE: When identifying professional license, abbreviations are acceptable so long as they are industry accepted abbreviations (e.g. LCSW, RN, MD, etc). If staff does not have a professional license/title, then job title should be identified. Job title should be based on functional role such as case manager, mental health rehabilitation specialist, and care coordinator. Abbreviations for job title should not be used unless the Agency has an official list of job titles and their abbreviations. The relevant identification number includes license, certification or registration numbers.

- 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)

- 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 students (a formal written agreement between the school and the Legal Entity must be in place for staff to be considered a student) 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.

MEDI-CAL MEDICAL NECESSITY

DESCRIPTION

Medical necessity is a term used by certain third party payers that encompasses criteria they feel are essential for reimbursement of services. If all the criteria making up medical necessity are not met, a payer will refuse or deny payment. While the wording of definitions varies slightly among payer sources, their intent is generally the same and compliance with one will often merit compliance with another.

The Medi-Cal Medical Necessity criteria has three components: diagnosis, impairment, and interventions. These are detailed below along with additional comments regarding EPSDT (Early Periodic Screening, Diagnosis, & Treatment) medical necessity criteria.

MEDICAL NECESSITY CRITERIA

All three of the following listed criteria must be met to be eligible for reimbursement (CCR §1830.205):

1. **An outpatient "included" diagnosis from the most current ICD code set.** A list of included diagnoses can be found here: http://file.lacounty.gov/SDSInter/dmh/1076803_Outpatient_DayServiceMedi-CalIncludedICD10DxCodes.pdf

   NOTE: Having a diagnosis that is not "included" does not exclude a client from having his/her services reimbursed AS LONG AS services/interventions are directed toward the impairment resulting from an "included" diagnosis. Services/interventions for Medi-Cal must be directed towards addressing the "included" diagnosis except while conducting the assessment or emergency/crisis services. The diagnosis which services/interventions are directed towards should be listed as the Primary Diagnosis in the Clinical Record and in the LACDMH electronic system and must be an included diagnosis if services are to be claimed to Medi-Cal. The primary diagnosis of an episode will be the diagnosis associated with a claim.

   In the LACDMH electronic system, all mental and behavioral health ICD diagnoses are listed, both those "included" and "excluded" for Medi-Cal reimbursement to allow practitioners to select the most accurate and appropriate diagnosis for the client

2. **Impairment as a result of the "included" Diagnosis.** At least **one** of the following must apply:
   a. a significant impairment in an important area of life functioning; e.g., living situation, daily activities, or social support
   b. a probability of significant deterioration in an important area of life functioning
   c. a probability a person under 21 years of age will not progress developmentally as individually appropriate (also see the following section on medical necessity for persons under 21 years of age)

NOTE: Impairments must clearly be identified in the Assessment along with a description of how those impairments are as a result of the included diagnosis. Simply stating or describing the impairment is not sufficient.

3. **Intervention**: **a person must meet <u>each</u> of the intervention criteria listed below.**
   a. The focus of the proposed intervention is to address the condition in 2 above.
   b. The expectation that the proposed intervention will:
      1) significantly diminish the impairment **OR**
      2) prevent significant deterioration in an important area of life functioning **OR**
      3) allow the child to progress developmentally as individually appropriate, unless conditions in the following section are met
   c. The condition would not be responsive to physical health care based treatment.

Other Allowable Medical Necessity Criteria for Persons Under 21 Years of Age (CCR §1830.210)

If persons under 21 do not meet criteria (2)-Impairment and (3)-Intervention above, medical necessity is met when all of the following exist:

1. The person has an included diagnosis (see http://file.lacounty.gov/SDSInter/dmh/1076803_Outpatient_DayServiceMedi-CalIncludedICD10DxCodes.pdf)
2. The person has a condition that would not be responsive to physical health care based treatment

AND

3. Specialty mental health services are needed to correct or ameliorate a defect, mental illness, or condition (Title 22, CCR §51340).

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)).

If it is determined that the client does not meet Medical Necessity, 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 medical necessity criteria; as well as provide a referral for non-specialty mental health services, and instructions on how to appeal the decision if they think it is incorrect.

DOCUMENTATION FOR MEDICAL NECESSITY
THE CLINICAL LOOP

While documentation rules include specific points at which medical necessity must be verified, these are not the only points at which medical necessity criteria must be met.

Every claimed service, other than those for the purpose of assessing medical necessity and crisis intervention, must meet medical necessity; i.e., the service must be directed towards reducing or ameliorating the effect of symptoms/behaviors of an included diagnosis causing functional impairments or, minimally, preventing an increase of those symptoms/behaviors or functional impairments. Each time a service is claimed, the staff person who delivered the service and submitted the claim is attesting that he/she believes the service met all medical necessity criteria as documented in the Clinical Record.

NOTE: This does not mean that every Progress Note must document all elements of medical necessity within the confines of the Progress Note. It simply means that there is sufficient documentation in the Clinical Record to support the intervention provided in the Progress Note.

THE CLINICAL LOOP

The "Clinical Loop" is the sequence of documentation that supports the demonstration of ongoing medical necessity and ensures all provided services are Medi-Cal reimbursable. All services claimed to Medi-Cal, except for services for the purpose of assessment or crisis intervention MUST fit into the Clinical Loop and support Medical Necessity in order to be reimbursed.

The standard sequence of documentation on which Medical Necessity requirements converge is:

- The Assessment - The completion of an **Assessment** establishes the foundation for an included diagnosis and impairments in life functioning.

- Needs Evaluation – The completion of a **Needs Evaluation** identifies underlying needs and social determinants of health to assist in the development of the Client Treatment Plan.

- The Client Treatment Plan - The demonstration of medical necessity is carried forward into the **Client Treatment Plan** where the diagnosis and impairments are used to establish treatment goals/objectives and the proposed interventions to effect the identified objectives.

- The Progress Note - **Progress Notes** document a service delivered that is related back to an intervention identified on the Client Treatment Plan. Progress Notes should also note the progress the client is making toward his/her objectives.

The Clinical Loop is not a one-time activity. The Clinical Loop occurs throughout the client's treatment and should be reviewed and updated on a regular basis to ensure current interventions are consistent with current symptoms/behaviors and impairments documented in the Clinical Record.

Triage may not be used to establish Medical Necessity. Triage should be used only to determine how quickly someone needs to be seen for an appointment. The lack of medical necessity can only be determined through an assessment completed by a practitioner within scope to diagnose. All Medi-Cal clients who want an assessment for Specialty Mental Health Services have the right to receive one and should not be denied one on triage alone.

ASSESSMENT
(LACDMH Policy 401.03)

D E S C R I P T I O N

An Assessment is important in 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. The assessment may be completed in one contact or over a period of time.

Assessments may only be completed by staff operating within their scope of practice and in accord with the Guide to Procedure Codes. Assessments must be completed for:

- New clients;
- Returning clients;
- Continuous clients.

In addition, assessments should be updated as clinically appropriate and whenever there is additional information gathered.

N E W C L I E N T A S S E S S M E N T

Assessments for new clients (i.e. clients that require the creation of a Clinical Record) must be completed prior to the initiation of treatment services and not to exceed 60

days from the initiation of services related to assessment. Only emergent services may be provided prior to the completion of the new assessment; however, minimally medical necessity must be established.

NOTE: Emergent Services are services needed to address an urgent condition which is "a situation experienced by a client that, without timely intervention, is highly likely to result in an immediate emergency psychiatric condition" (California Code of Regulations 1810.253).

Any program accepting a client is responsible for ensuring there is a current, complete (all data elements below addressed) and accurate Assessment in the Clinical Record. If the program is accepting a new client referred or transferred from another program, the accepting program may choose to do their own new client assessment or, based on clinical judgment, use the assessment from the referring program with or without supplementing that assessment with a returning client assessment or assessment addendum.

Although all new client assessments must include the below required data elements, the emphasis placed on each element should be consistent with the specific purpose of the assessment. An assessment administered for one purpose (e.g., immediate and non-ongoing services) may be inappropriate for use for another purpose (e.g., a general evaluation to determine presence/absence of mental health treatment needs). This should be taken into consideration when determining whether to accept an existing assessment or to conduct a new assessment.

If using the LACDMH paper forms, the Full Assessment (or the Infancy, Childhood & Relationship Enrichment Initial Assessment - ICARE) should be used. In almost all cases, Directly-Operated Providers in the Integrated Behavioral Health Information System (IBHIS) should use the Full Assessment (or ICARE). In cases where the purpose of assessment is to provide information for immediate and non-ongoing services, Directly-Operated Providers in IBHIS may use a QA approved form and procedure with all required data elements below. Contractors with an EHRS should use the relevant form with all required data elements below per DMH Policy 401.02.

NOTE: The LACDMH paper Full Assessment includes optional prompts to assist the clinician in identifying possible areas of inquiry. Only the below identified data elements are required.

New Client Assessment Requirements:

(State Contract unless otherwise noted):

- Assessor Information (LACDMH)
  - *Name*
  - *Discipline*
- Identifying Information and Special Service Needs (LACDMH)
  - *Name of Client*
  - *Date of Birth*
  - *Gender*
  - *Ethnicity*

    - *Preferred Language*
    - *Other relevant information*
- For Children, Biological Parents, Caregivers and Contact Information (LACDMH)
    - *Names*
    - *Contact Information (phone or address)*
    - *Other relevant information*
- Presenting problem(s): The client's chief complaint, history of presenting problem(s), including current level of functioning, relevant family history and current family information;
    - *Precipitating Event/Reason for Referral*
    - *Current Symptoms/Behaviors including intensity, duration, onset and frequency*
    - *Impairments in Life Functioning*
- Client Strengths: Documentation of the beneficiary's strengths in achieving client plan goals;
    - *Client strengths to assist in achieving treatment goals*
- Mental Health History: Previous treatment, including providers, therapeutic modality (e.g. medications, psychosocial treatments) and response, and inpatient admissions. If possible, include information from other sources of clinical data, such as previous mental health records, and relevant psychological testing or consultation reports;
    - *Psychiatric Hospitalizations including dates, locations and reasons*
    - *Outpatient Treatment including dates, locations and reasons*
    - *Response to Treatment, Recommendations, Satisfaction with Treatment*
    - *Past Suicidal/Homicidal Thoughts or Attempts*
    - *Other relevant information*
- Risks: Situations that present a risk to the beneficiary and/or others, including past or current trauma;

NOTE: Examples of risks include (DHCS Information Notice No.: 17-040):

- ✓ History of Danger to Self (DTS) or Danger to Others (DTO);
- ✓ Previous inpatient hospitalizations for DTS or DTO;
- ✓ Prior suicide attempts;
- ✓ Lack of family or other support systems;
- ✓ Arrest history, if any;
- ✓ Probation status;
- ✓ History of alcohol/drug abuse;
- ✓ History of trauma or victimization;
- ✓ History of self-harm behaviors (e.g., cutting);
- ✓ History of assaultive behavior;
- ✓ Physical impairments (e.g., limited vision, deaf, wheelchair bound) which make the client vulnerable to others; and
- ✓ Psychological or intellectual vulnerabilities (e.g., intellectual disability (low IQ), traumatic brain injury, dependent personality).

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

    - *Dosage/Frequency*
    - *Period Taken*
    - *Effectiveness, Response, Side Effect, Reactions*
    - *Other relevant information*
- Substance Exposure/Substance Use: Past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over-the-counter, and illicit drugs;
- Medical History: Relevant physical health conditions reported by the client or a significant support person. Include name and address of current source of medical treatment. For children and adolescents: include prenatal and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports;
    - *Doctor's name and contact information*
    - *Allergies*
    - *Relevant medical information*
    - *Developmental History (for children)*
    - *Developmental milestones and environmental stressors (for children)*
- Relevant conditions and psychosocial factors affecting the client's physical health and mental health; including, as applicable, living situation, daily activities, social support, cultural and linguistic factors and history of trauma or exposure to trauma;
    - *Education/School history, status, aspirations*
    - *Employment History/Vocational information including means of financial support (for adults)*
    - *Legal/Juvenile court history and current status*
    - *Child abuse/protective service information (for children)*
    - *Dependent Care Issues (for adults)*
    - *Current and past relevant Living Situations including Social Supports*
    - *Family History/Relationships*
    - *Family strengths (for children)*
    - *Other relevant information*
- Mental Status Examination;
    - *Mental Status Examination*
- Clinical formulation based on presenting problems, history, mental status examination and/or other clinical data;
    - *Clinical formulation*
- A diagnostic descriptor consistent with the clinical formulation
    - *Diagnostic descriptor*
- A code from the most current ICD code set shall be documented consistent with the diagnostic descriptor;
    - *ICD diagnosis code*
    - *Specialty Mental Health Services Medical Necessity Criteria*
- Signature of a staff person allowed to perform a Psychiatric Diagnostic Assessment per the Guide to Procedure Codes
    - *Staff signature, discipline/title, identification number (if applicable) and date*

RETURNING CLIENT ASSESSMENT

Assessments for returning clients (i.e. clients returning for services after termination of services per LACDMH Policy 312.01 or 180 days of inactivity and NOT requiring a new Clinical Record) must be completed within 60 days of the initiation of services related to assessment or treatment. Any program accepting a returning client is responsible for ensuring there is an assessment with the below data elements in the Clinical Record. If the program is accepting a returning client referred or transferred from another program, the accepting program may choose to do their own returning client assessment or, based on clinical judgment, use the assessment from the referring program with or without supplementing that assessment with an assessment addendum.

If using the LACDMH paper forms, the Re-Assessment should be used. In almost all cases, Directly-Operated Providers in the Integrated Behavioral Health Information System (IBHIS) should use the Assessment Addendum form and select the Returning Client type. In cases where the purpose of assessment is to provide information for immediate and non-ongoing services, Directly-Operated Providers in IBHIS may use a QA approved form and procedure with all required data elements below. Contractors with an EHRS should use the relevant form with all required data elements below.

Client Returning for Services Assessment Requirements:

- *Precipitating Event/Reason for Referral*
- *Current Symptoms/Behaviors including intensity, duration, onset and frequency*
- *Impairments in Life Functioning*
- *Client Strengths to assist in achieving treatment goals*
- *Updates/Changes to*
    - *Mental Health History including history of problem prior to precipitating event, psychiatric hospitalizations and outpatient treatment*
    - *Medications*
    - *Substance Use*
    - *Medical*
    - *Psychosocial History including education, employment, legal, current living arrangements and social supports, dependent care issues and family/relationships*
    - *Developmental History (for children)*
- *Mental Status Examination*
- *Clinical Formulation and Diagnostic Descriptor*
- *ICD Code consistent with clinical formulation and diagnostic descriptor*
- *SMHS Medical Necessity Criteria*
- *Staff signature, discipline/title, identification number (if applicable) and date*

CONTINUOUS CLIENT ASSESSMENT

Assessments for continuous clients (i.e. clients who have not had treatment terminated or 180 days of inactivity) must be completed every 3 years. The assessment should be completed three years from the date of the last assessment (either a new client assessment, returning client assessment or continuous client assessment). Any program treating a client for 3 continuous years is responsible for ensuring there is an assessment with the below data elements in the Clinical Record.

If using the LACDMH paper forms, the Re-Assessment should be used. Directly-Operated Providers in the Integrated Behavioral Health Information System (IBHIS) should use the Assessment Addendum form and select the Continuous Client type or a Medication Service Progress Note that includes the required data elements below. Contractors with an EHRS should use the relevant form with all required data elements below.

Continuous Client Assessment Requirements:

- *Current Symptoms/Behaviors including intensity, duration, onset and frequency*
- *Impairments in Life Functioning*
- *Client Strengths to assist in achieving treatment goals*
- *Updates/Changes to*
    - *Mental Health History including psychiatric hospitalizations and outpatient treatment*
    - *Medications*
    - *Substance Use*
    - *Medical*
    - *Psychosocial History including education, employment, legal, current living arrangements and social supports, dependent care issues and family/relationships*
    - *Developmental History (for children)*
- *Mental Status Examination*
- *Clinical Formulation and Diagnostic Descriptor*
- *ICD Code consistent with clinical formulation and diagnostic descriptor*
- *Staff signature, discipline/title, identification number (if applicable) and date*

NEEDS EVALUATION
(LACDMH Policy 401.03)

D E S C R I P T I O N

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.

I N I T I A L N E E D S E V A L U A T I O N

For all newly active clients for whom it is determined medical necessity has been met, a Needs Evaluation must be completed prior to the development of the client treatment plan. 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, Mutual and Unilateral Termination of Mental Health Services, or an existing client returning for services after 180 days of inactivity requiring the resumption of documentation in an existing clinical record.

O N G O I N G N E E D S E V A L U A T I O N

For clients 21 and over who are receiving TCM services, a Needs Evaluation must be conducted annually, at minimum. Best practice is to tie the annual needs evaluation to the treatment plan completion.

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.

ASSESSMENT & NEEDS EVALUATION ADDENDUM

An addendum to the Assessment or Needs Evaluation is required when there is additional information gathered, whether a change or an addition, after the completion of an Assessment/Needs Evaluation and prior to providing any services that are not justified by the current Assessment/Needs Evaluation.

If using the LACDMH paper forms, the Assessment Addendum or Needs Evaluation Tool (NET) or Child and Adolescent Needs and Strengths (CANS) may be used, depending on the type of information and practitioner's scope of practice. Directly-Operated Providers in the Integrated Behavioral Health Information System (IBHIS) may use the Assessment Addendum form and select Addendum type, the NET or the CANS. For Contractors with an EHRS, the relevant form should be used.

CLIENT TREATMENT PLAN

(LACDMH Policy 401.03)

DESCRIPTION

Consistent with the philosophy and requirements of State and Federal funding sources, the Client Treatment Plan focuses on individualized, strengths-based services; addresses linguistic and interpretive needs; supports family involvement and encourages client participation and agreement with the plan. It is best practice for treatment planning to occur with the client present and there must be evidence of the client's participation in the treatment planning process. The client's signature on the Client Treatment Plan provides this evidence. The Client Treatment Plan is not effective until signed (and co-signed if required) and dated by the required staff members (State Contract; CCR §1810.440; DHCS Information Notice No.:17-040). See "Additional Information" below for signature requirements.

The Client Treatment Plan must clearly address the mental health needs (e.g. symptoms, behaviors and/or impairments requiring improvement) identified in the most current Assessment and utilize the client's strengths to achieve his/her goals.

It is best practice for Client Treatment Plan objectives, and the proposed interventions supporting those objectives, to be written to the Client Treatment Plan by an AMHD for whom the services are within scope of practice. When the services are outside the

scope of practice of the writer, irrespective of whether the writer is an AMHD, a face-to-face discussion between the writer and an individual for whom the interventions are within scope of practice must take place prior to the objectives/interventions being written. This discussion must be of sufficient detail as to provide the writer with clear direction on all materially important treatment related elements of the objectives/interventions. In these instances, the responsibility for the content of the objectives/interventions that result from the aforementioned process remains with the individual for whom the interventions are within scope of practice.

A Client Treatment Plan must be completed prior to providing treatment services. Treatment services are those services that address the client's mental health needs that are not primarily for the purpose of assessment under any type of service, plan development under any type of service, and crisis intervention/stabilization; or, if an urgent condition exists, an emergent medication support and/or targeted case management service (DHCS Information Notice No.: 17-040).

NOTE: Emergent Services are services needed to address an urgent condition which is "a situation experienced by a client that, without timely intervention, is highly likely to result in an immediate emergency psychiatric condition" (California Code of Regulations 1810.253).

All treatment services provided under the following types of services must be associated with an objective(s) on the Client Treatment Plan:

- Mental Health Services
- Medication Support Services
- Targeted Case Management
- Intensive Care Coordination (ICC)
- Intensive Home Based Services (IHBS)Therapeutic Behavioral Services (TBS)
- Therapeutic Foster Care (TFCS)
- Day Treatment Intensive
- Day Rehabilitation
- Crisis Residential
- Adult Residential

Client Treatment Plans must be completed for all above treatment services and fall into two categories:

- Annual;
- Update

The Annual Client Treatment Plan covers all services to be provided to a client. The Update Client Treatment Plan is an addendum to the Annual. It covers those objectives or services to be reviewed, added, modified, or deleted prior to the review deadline of the Annual Client Treatment Plan.

ANNUAL CLIENT TREATMENT PLAN

The Annual Client Treatment Plan is required after the completion of a new client assessment or returning client assessment and prior to the initiation of treatment services for a client. For Crisis Residential Services the Client Treatment Plan must be completed within 72 hours of admission to the program.

The Annual Client Treatment Plan shall also be reviewed and modified, if appropriate, minimally every 365 days from the start date of the last Annual Client Treatment Plan. If the client is not available to participate in the review prior to the expiration of the 365-day period, the Annual Client Treatment Plan shall be reviewed and updated with the client at the next contact with the client and prior to additional treatment services being provided. The review shall be documented in the progress note, including the outcome(s) of the previous treatment plan.

Annual Client Treatment Plan Required Elements:

(State Contract except as otherwise noted)

- Statement of long-term goals (treatment outcome) in the client's words (LACDMH Requirement);
- Specific observable and/or specific quantifiable goals/treatment objectives related to the client's mental health needs and functional impairments as a result of the mental health diagnosis;
- Proposed types(s) of intervention /modality (e.g. individual vs group, rehabilitation vs therapy) including a detailed description of the interventions to be provided;
- Proposed frequency and duration (if less than one year) of interventions;
- Interventions that focus and address the identified functional impairments as a result of the mental disorder; have interventions that are consistent with the client plan goal [objective];
- Be consistent with the qualifying diagnoses;
- Client and family involvement (LACDMH)
- Documentation that a copy of the plan was offered to the client
- Linguistic and interpretive needs (LACDMH)
- Required staff signature, discipline/title, relevant identification number (if applicable) and date (see below for additional information)
- Client/Legal Representative (see below for additional information)

UPDATE CLIENT TREATMENT PLAN

An Update Client Treatment Plan shall be done for the objectives associated with the following types of service and mandated review periods (LACDMH):

- Crisis Residential Treatment - Weekly;
- Adult Residential Treatment – Every 6 Months;
- Therapeutic Behavioral Services – Every 6 Months;

- Intensive Home Based Services – Every 6 Months;
- Therapeutic Foster Care – Every 6 Months
- Day Treatment Intensive – Every 3 Months;
- Day Rehabilitation – Every 6 Months.

Each objective associated with an above type of service on the Client Treatment Plan shall be reviewed, renewed, updated/modified or deleted (as appropriate) prior to the due date or prior to services being provided after the review date.

The Update Client Treatment Plan shall also be completed as clinically appropriate (i.e. when a change in treatment is warranted). This would include adding an objective(s) and/or intervention(s) or editing an objective(s) and/or intervention(s) on the current Client Treatment Plan.

Update Client Treatment Plan Required Elements:

When renewing, adding or modifying the Client Treatment Plan, the following elements must be present and up-to-date:

- Statement of long-term goals (treatment outcome) in the client's words (LACDMH Requirement);
- Specific observable and/or specific quantifiable goals/treatment objectives related to the client's mental health needs and functional impairments as a result of the mental health diagnosis;
- Proposed types(s) of intervention /modality (e.g. individual vs group, rehabilitation vs therapy) including a detailed description of the interventions to be provided;
- Proposed frequency and duration (if less than one year) of interventions;
- Interventions that focus and address the identified functional impairments as a result of the mental disorder; have interventions that are consistent with the client plan goal [objective];
- Be consistent with the qualifying diagnoses;
- Client and family involvement (LACDMH)
- Documentation that a copy of the plan was offered to the client
- Linguistic and interpretive needs (LACDMH)
- Required staff signature, discipline/title, relevant identification number (if applicable) and date (see below for additional information)
- Client/Legal Representative (see below for additional information)

When an Update Client Treatment Plan is done, required data elements may be carried over from the previous Client Treatment Plan. All Update Client Treatment Plans must have new required staff signature(s). If any required data elements are added or modified, then a new client/legal representative signature must be obtained.

ADDITIONAL INFORMATION

Required Staff Signatures:

- An Authorized Mental Health Discipline (AMHD) (CCR §1840.314; State Contract);

  NOTE: Signature by an AMHD minimally means services are under the direction of, or in consultation with, the AMHD (see General Documentation Rules).

- The staff person who has written the plan (LACDMH);
- If applicable, a staff person within scope of practice for any interventions outside the scope of practice of the AMHD (e.g., if prescribing medications is an indicated intervention, an MD/DO, NP, PA or qualified pharmacist must sign) (LACDMH);

  NOTE: When doing a Client Treatment Plan update, a staff person within scope of practice is only required for those data elements being added/modified.

- For services claimed to Medicare/Private Insurance: an MD/DO (Medicare and Private Insurance Carriers as noted in LACDMH Policy 401.04).

Required Client/Legal Representative Signatures:

- The Client or Legal Representative (State Contract)

When the client's signature or the signature of the client's legal representative is required on the Client Treatment Plan and the client refuses or is unavailable for signature, the Client Treatment Plan shall include a written explanation of the refusal or unavailability. (State Contract). For instances where the client or client's legal representative is unavailable due to services being provided via phone or telehealth, verbal agreement with the treatment plan should be obtained. The client/legal representative's verbal agreement to the treatment plan is equivalent to a signature and should be documented on the client treatment plan.]

NOTE: In cases where the client is unable to sign the plan due to his/her mental state (e.g. agitated or psychotic), it is best practice to make subsequent attempts to obtain the signature when the clinical record indicates that the situation that justified the initial absence of signature is no longer a factor or in effect.

When the client or other required participant in the treatment planning process is unwilling to sign the Client Treatment Plan due to a disagreement with the plan, it is best practice to make every reasonable effort to adjust the Client Treatment Plan in order to achieve mutually agreed-upon acceptance by the client or other required participant, and the clinician

PROGRESS NOTES
(LACDMH Policy 401.03)

D E S C R I P T I O N

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 must be used to describe how services provided reduced impairment, restored functioning or prevented significant deterioration in an important area of life functioning outlined in the Client Treatment Plan.

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 following section. A progress note must be completed prior to the submission of any claim.

P R O G R E S S N O T E S

Progress Note Requirements:
(State Contract except as otherwise noted)

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

- Date of service;
- Procedure code (LACDMH);
- Duration of service (Face-to-Face Time and all Other Time for Mode 15);
    - Face-to-face time is the time spent providing a service to a client or parent/guardian who is physically present. Telehealth services with the client are considered face-to-face while telephone services with the client are not.
    - Other time includes time spent documenting or travelling to a reimbursable service, directing a service to a collateral, case-related interactions with other service providers/treatment team members, or providing telephone services to the client.
- For group, the total number of clients present or represented;
- Relevant aspects of client care, including documentation of medical necessity;
- Relevant clinical decisions, when decisions are made, alternative approaches for future interventions;
- Interventions applied by each practitioner;
- Client's response to the interventions;
- Location of the interventions;
- Referrals to community resources and other agencies, when appropriate;

- Follow-up care, or as appropriate, a discharge summary;
- Signature of the person providing the service (or electronic equivalent);, discipline/title, relevant identification number (if applicable) and date documented

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 the 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. A discharge summary includes the following elements:

- A brief treatment summary;
- A status update on the client's progress toward their treatment plan objectives;
- Referrals provided (if applicable);
- Reason for termination of services;
- Follow-up plans (if applicable);
- Other pertinent information such as whether medications were provided upon termination.

Signature Requirements

See General Documentation Rules for additional information regarding signature and co-signature requirements.

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. The signature (or electronic equivalent) of the person providing the service including the person's type of professional degree, licensure or job title; and the relevant identification number (if applicable) must be on every progress note.

When more than one practitioner participates in the same service, the names of each staff participating in the service must be included in the note with his/her specific intervention/contribution and time. Only the signature (or electronic equivalent) of the practitioner writing the note is required.

Frequency of Progress Notes

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

- Every service contact
  - ✓ Mental Health Services
  - ✓ Medication Support Services
  - ✓ Crisis Intervention
  - ✓ Targeted Case Management
  - ✓ Intensive Care Coordination
  - ✓ Intensive Home Based Services
  - ✓ Therapeutic Behavioral Services
- Daily
  - ✓ Crisis Residential

- ✓ Crisis Stabilization (1x/23hr period)
- ✓ Day Treatment Intensive
- ✓ Therapeutic Foster Care

- Weekly
  - ✓ Day Treatment Intensive: Clinical Summary
  - ✓ Day Rehabilitation
  - ✓ Adult Residential

SERVICE COMPONENTS
(State Plan Amendments)

D E F I N I T I O N

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. To be reimbursed under the Medicaid program, the need for the treatment service must be established by an assessment and documented in the client care plan. 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.

S E R V I C E C O M P O N E N T S

All definitions are from the DHCS State Plan Amendment (SPA) unless otherwise noted. Service components lacking specific SPA definitions must conform to the general requirement of addressing identified mental health needs as established by an assessment and documented in the client treatment plan (aka the clinical loop). 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 evaluate the current status of a client's mental, emotional, or behavioral health. Assessment includes one or more of the following: mental status determination, analysis of the client's clinical history, analysis of relevant biopsychosocial and cultural issues and history, diagnosis, and the use of testing procedures.

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)

Collateral: A service activity to a significant support person or persons in a client's life for the purpose of providing support to the client in achieving client treatment plan goals. Collateral includes one or more of the following: consultation and/or training of the significant support person(s) that would assist the client in increasing resiliency, recovery, or improving utilization of services; consultation and training of the mental illness and its impact on the client; and family counseling with the significant support person(s) to improve the functioning of the client. The client may or may not be present for the service activity.

NOTE: Collateral sessions (with one or more clients represented) must be directed exclusively to the mental health needs of the client [CCR §1840.314(b)]. Examples are: interpretation or explanation of results of psychiatric, other medical examinations or procedures, or other accumulated data to family or significant other(s), or advising them how to assist the client.

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 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.

Evaluation of Clinical Effectiveness and Side Effects

Evaluation of the Need for Medication

Medication Education: Includes the instruction of the use, risks, and benefits of and alternatives for medication

Medication Support Services: Includes one or more of the following: 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 are individually tailored to address the client's need and are provided by a consistent provider who has an established relationship with the client.

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

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.

Obtaining Informed Consent

NOTE: For Medication Support Services only.

Plan Development: A service activity that consists of one or more of the following: development of client treatment plans, approval of client treatment plans and/or monitoring of a client's progress.

NOTE: If the plan development is related to a service activity which falls under the general service description of Mental Health Services, then Mental Health Services should be claimed. If the plan development is related to a service activity which falls under the general service description of Medication Support Services, then Medication Support Services should be claimed. If the plan development is related to a service activity which falls under Targeted Case Management, then Targeted Case Management should be claimed. If the plan development is related to a service activity which falls under Crisis Intervention, then Crisis Intervention should be claimed. In each of these cases, the service must be within the scope of practice of the practitioner claiming for the service.

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)

Psychotherapy: The use of psychological methods within a professional relationship to assist the client or clients to achieve a better psychosocial adaptation, to acquire a greater human realization of psychosocial potential and adaptation, to modify internal and external conditions that affect individual, groups, or communities in respect to behavior, emotions and thinking in respect to their intrapersonal and interpersonal processes. Psychotherapy shall be provided by licensed, registered, or waivered staff practicing within their scope of practice. Psychotherapy does not include physiological interventions, including medication intervention. (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: Linkage to other needed services and supports.

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)

Rehabilitation: A recovery or resiliency focused service activity identified to address a mental health need in the client treatment plan. 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 client. Rehabilitation also includes support resources, and/or medication education. Rehabilitation may be provided to a client or a group of clients.

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: A service activity that is a 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 client 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 a group of clients and may include family therapy directed at improving the client's functioning and at which the client is present.

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)

CHAPTER 2

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

SERVICE OVERVIEW & REIMBURSEMENT RULES
- **General Rules**
- **Documentation 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

GENERAL RULES

The reimbursable unit for these services is staff time reported in the DMH electronic data system and claimed in minutes. Medicare reimburses for individual services based on face-to-face time, hence to appropriately claim to both Medicare and Medi-Cal, the total service time for any Rendering Provider must be broken out into face-to-face and other time to ensure the correct Procedure Code selection. When required, both of these times will need to be entered into the DMH electronic system and documented in the clinical record. The total time is used for claiming to Medi-Cal.

NOTE: All Mental Health Services must have authorization from the Department's Central Authorization Unit prior to delivery when delivered in conjunction with Day Treatment Intensive or Day Rehabilitation.

DOCUMENTATION RULES

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

Frequency of Documentation:

For all Mode 15 services including Mental Health Services, Medication Support Services, Crisis Intervention, Targeted Case Management, Therapeutic Behavioral Services, Intensive Care Coordination and Intensive Home Based Services, every service contact must be documented on a separate progress note.

NOTE: For the purpose of Targeted Case Management, a single service contact may include multiple service activities (e.g. telephone calls) performed within the same calendar day and intended to accomplish the same specific objective.

Claiming:

- The exact number of minutes used by persons providing a reimbursable service shall be reported and billed (CCR §1840.316).
- 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.

- For group services, the staff members' time must be prorated to each client based on the total number of persons receiving the service. This number must include both DMH and non-DMH clients to ensure that Medi-Cal is not claimed time for services to non-beneficiaries.

- When more than one staff member provides a service to one or more client(s) at the same time, the total time spent by all staff shall be added together to yield the total claimable services.

Site and Contact Requirements:

The following applies to Mental Health Services (CCR §1840.324); Medication Support Services (CCR §1840.326); Crisis Intervention (CCR §1840.336); and Targeted Case Management (CCR §1840.342):

Services may be provided face-to-face, by telephone or by telepsychiatry with the client or significant support persons. Services may be provided anywhere in the community.
NOTE: Not all DMH procedure codes may be used for services provided in all of these ways.

Documentation Rules:

- Progress Notes must explicitly document how services without face-to-face or telephone contact with the client (e.g. report writing, consultation, record review and plan development) benefit the client and meet the requirements of Medical Necessity.

- When services are being provided to or on behalf of a client by two or more staff in a single contact each person'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.

- When two or more significant and distinct services or service types are delivered within a single contact, each service must be documented in a separate progress note that meets all documentation requirements. It is not appropriate to combine multiple significant and distinct services under a single progress note that simply reflects the predominant service.

  NOTE: Plan Development services are an exception and may be combined into a single progress note with another service.

- When two or more staff provide significant and distinct services in a single contact, each staff should write a separate note and claim separately to an appropriate procedure code for the service provided by that individual staff member.

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.

Service Components (State Plan Amendment)

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

- Assessment
- Plan Development
- Therapy
- Rehabilitation
- Collateral

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
- 10 – Collateral
- 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.

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), or Psychiatric Health Facility Services (CCR §1840.370) are reimbursed, except on the day of admission to any of 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).

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:

- For psychological testing, separate claims may be submitted, with appropriate accompanying documentation, for both the administration of tests and the preparation of the report in accord with the date the services were actually delivered.

- Psychological Testing is a psychodiagnostic assessment of personality, development and cognitive functioning. For children, referrals are made to clarify symptomatology, rule out diagnoses and help delineate emotional from learning disabilities.

MEDICATION SUPPORT SERVICES

Definition (State Plan Amendment):

Medication support services include one or more of the following: 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 are individually tailored to address the client's need and are provided by a consistent provider who has an established relationship with the client.

Service Components (State Plan Amendment)

Medication Support Service components include:

- Evaluation of the need for medication
- Evaluation of clinical effectiveness and side effects of medication
- The obtaining of informed consent
- Medication education including instruction in the use, risks and benefits of and alternatives for medication
- Collateral
- Plan Development

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.

⇒ 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 and one claim submitted that includes the time of 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 with each staff submitting his/her own claim with his/her own time.

- 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.

Informed Consent

- If psychiatric medications are prescribed, there must be a medication specific Informed Consent completed and placed in the Clinical Record that includes the following data elements:
    - The reason for taking such medications
    - Reasonable alternative treatments available, if any
    - Type of medication
    - Range of frequency (of administration)
    - Amount (dosage)
    - Method of administration
    - Duration of taking the medication
    - Probable side effects
    - Possible additional side effects if taken longer than 3 months
    - Consent once given may be withdrawn at any time
    - Date of medication consent
    - Signature of the person providing the service, type of professional degree and licensure/job title

  NOTE: It is acceptable for the medication consent to include attestations, signed by the provider and client, that the provider discussed each of the required components of the medication consent with the client. The use of check boxes on the medication consent form indicating the provider discussed the need for medication and potential side effects is acceptable as long as the information is included in accompanying written materials provided to the client. The reasons a provider prescribed a medication for a client must be documented in the client's clinical record, but is not required specifically on the medication consent form (Information Notice No.: 17-040).

- 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 require additional documentation within the clinical record of (1) the method of administration of the medicine(s), and (2) the possible additional side effects if the medication(s) is taken longer than 3 months.

- The Informed Consent with the client or guardian must be completed:

  a. When a new psychiatric medication is prescribed;
  b. At least annually, even in the absence of medication changes; and
  c. When the client resumes taking psychiatric medication following documented withdrawal of consent for treatment.

- Directly-Operated programs shall utilize an approved DMH form to document Informed Consent such as the Medication Consent and Treatment Plan.

C R I S I S I N T E R V E N T I O N

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.

Service Components (State Plan Amendment)

Crisis Intervention service components include:

- Assessment
- Collateral
- Therapy
- Referral

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.

⇒ 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.

T A R G E T E D C A S E M A N A G E M E N T

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:

- o Psychiatric Inpatient Hospital Services
- o Psychiatric Health Facility Services
- o 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 (State Plan Amendment):

Comprehensive and Periodic Re-Assessment – For any client receiving TCM services, there must be an annual TCM needs evaluation (refer to Chapter 1 Needs Evaluation).

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

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.

⇒ 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 the medical necessity 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 following documents:

- 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);
- Initial Full Assessment and any more recent assessments;
- Current Client Treatment Plan which must include the proposed interventions for TBS.

For subsequent authorization requests, the following documents must be submitted:

- New Supplemental TBS Assessment form indicating the current clinical need for the service and signed by an Authorized Mental Health Discipline;
- Initial Full Assessment (if not previously submitted) and any recent assessments since the original authorization request submission;
- Current Client Treatment Plan which must include any new/updated proposed interventions for TBS.

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 that are the result of the covered mental health diagnosis 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 defects and 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 medical necessity criteria for these specialty mental health services as set forth in CCR, Title 9, Section 1830.210

ICC and IHBS must be provided to all children and youth who meet medical necessity criteria for [these] services. 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.

The ICC Eligibility Form includes the following criteria, which should be considered as indicators of need for ICC and IHBS and are intended to be used to identify children and youth who should be assessed for whether ICC and/or IHBS are medically necessary. Thus, 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. IThe 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, plus documentation and travel time.
- 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.

INTENSIVE HOME BASED SERVICES

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:

- Plan Development
- Rehabilitation
- Collateral

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 following documents:

   - 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);
   - Initial Full Assessment and any more recent assessments;
   - Current Client Treatment Plan which must include the proposed interventions for IHBS.

   For subsequent authorization requests, the following documents must be submitted:

   - New Supplemental IHBS Assessment form indicating the current clinical need for the service and signed by an Authorized Mental Health Discipline;
   - Initial Full Assessment (if not previously submitted) and any recent assessments since the original authorization request submission;
   - Current Client Treatment Plan which must include any new/updated proposed interventions for IHBS.

For Contracted providers, the documents must be submitted via the Provider Connect module of the Integrated Behavioral Health Information System (IBHIS). 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 6-month period or 9,999 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 IHBS 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 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 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 medical necessity criteria.

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 following documents:

   - 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);
   - Initial Full Assessment and any more recent assessments;
   - Current Client Treatment Plan which must include the proposed interventions for TFCS.

   For subsequent authorization requests, the following documents must be submitted:

   - New Supplemental TFCS Assessment form indicating the current clinical need for the service and signed by an Authorized Mental Health Discipline;
   - Initial Full Assessment (if not previously submitted) and any recent assessments since the original authorization request submission;
   - Current Client Treatment Plan which must include any new/updated proposed interventions for TFCS.

   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, 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 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.

CRISIS STABILIZATION SERVICES

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).

- 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).

D A Y T R E A T M E N T I N T E N S I V E

Day Treatment Intensive (State Plan Amendment)

Day Treatment Intensive service is a structured, multi-disciplinary program including community meetings, a therapeutic milieu, therapy, skill building groups, and adjunctive therapies, which provides services to a distinct group of individuals. It may also include rehabilitation, process groups and other interventions. Day Treatment Intensive is intended to provide an alternative to hospitalization, avoid placements 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. The Day Treatment Intensive program is a program that lasts less than 24 hours each day.

Service Components (State Plan Amendment)

Day Treatment Intensive services must include the following service components:

- Community Meetings
- Therapeutic Milieu
- Process Groups (State Contract)
- Skill-Building Groups
- Adjunctive Therapies
- Psychotherapy (State Contract)

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

- Assessment
- Plan Development
- Therapy
- Collateral
- Rehabilitation

Frequency and Requirements of Documentation

For Day Treatment Intensive, there must be daily progress notes and a weekly clinical summary. 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)
- If the client was unavoidably absent and does not attend all of the scheduled hours of the Day Treatment Intensive program, there must be a separate entry that documents the reason for the unavoidable absence and the total time the client actually attended the program (State Contract).

NOTE: Examples of unavoidable absence include (DHCS Information Notice No.: 17-040):

- ✓ Family emergency;
- ✓ Client became ill;
- ✓ Court appearance;
- ✓ Appointment that cannot be rescheduled (note needs to explain why an appointment cannot be rescheduled);
- ✓ Family event (e.g. funeral, wedding);
- ✓ Transportation issues

The weekly clinical summary for Day Treatment Intensive must include:

- Dates of service within the time period covered by the note
- A summary describing what was attempted and/or accomplished toward the client's goals(s) by the client and service staff.
- Status of the client (symptoms, behaviors, impairments justifying continued Day Treatment Intensive services)
- Plan (should interventions be modified, do other behaviors need to be addressed)

- Staff signatures, discipline and licenses/registration number

NOTE: The weekly Clinical Summary must be reviewed and signed by a staff member who meets the qualifications of an AMHD, and who is either staff to the DTI program or the person directing the services (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).

- If a client is unavoidably absent and does not attend all of the scheduled hours of the Day Treatment Intensive program, Day Treatment Intensive services may only be claimed if the client is present at least 50% of scheduled hours of operation for that day (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.

- 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):

- Day Treatment Intensive services must be authorized by the Department prior to delivery and claiming.

- 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 on 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 of experience 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

Day Rehabilitation (State Plan Amendment)

Day Rehabilitation is a structured program including rehabilitation, skill building groups, process groups, and adjunctive therapies which provides services to a distinct group of individuals. It may also include therapy, and other interventions. 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.

Service Components (State Plan Amendment)

Day Rehabilitation services must include the following service components:

- Community Meetings
- Therapeutic Milieu
- Process Groups (State Contract)
- Skill-Building Groups
- Adjunctive Therapies

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

- Assessment
- Plan Development
- Therapy
- Rehabilitation
- Collateral
- Psychotherapy (State Contract)

Frequency and Requirements of Documentation

For Day Rehabilitation services, progress notes must be completed weekly, at a minimum. In addition to the elements identified in Chapter 1 Progress Notes, the weekly progress notes for Day Rehabilitation must include:

- Time period covered by the note
- Dates of service within the time period covered by the note
- The total number of minutes/hours the client actually attended the program for each date of service (State Contract)
- A summary describing what was attempted and/or accomplished toward the client's goals(s) by the client and service staff.

- If the client was unavoidably absent and does not attend all of the scheduled hours of the Day Rehabilitation program, there must be a separate entry that documents the reason for the unavoidable absence and the total time the client actually attended the program (State Contract).
- The signature of a staff member who provided services on each date of service. One signature may cover multiple dates of service for that staff.

NOTE: Each date of service must be accounted for by the signature of a staff member who actually provided services on that date (i.e. more than one staff member may be required to sign the weekly progress note in order to cover all dates of service within the time period covered by the note). One staff signature is sufficient to cover multiple dates the staff provided services.

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

NOTE: Programs may opt to use daily notes for Day Rehabilitation to document the dates of service during the week, the total duration the client was actually present each date of service, and the activities and interventions provided to the client. The use of daily notes does not negate the requirement for a weekly progress note that summarizes the week's activities/interventions and progress toward client goal(s).

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 include at a minimum:

- 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, or each date of service on the weekly progress note.

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.

- If a client is unavoidably absent and does not attend all of the scheduled hours of the Day Rehabilitation program, Day Rehabilitation services may only be claimed if the client is present at least 50% of scheduled hours of operation for that day.

NOTE: Examples of unavoidable absence include (DHCS Information Notice No.: 17-040):

- ✓ Family emergency;
- ✓ Client became ill;
- ✓ Court appearance;
- ✓ Appointment that cannot be rescheduled (note needs to explain why an appointment cannot be rescheduled);
- ✓ Family event (e.g. funeral, wedding);
- ✓ Transportation issues

- 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.

- ➢ 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.

- 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).

S O C I A L I Z A T I O N D A Y S E R V I C E S

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 4

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 includes a range of activities and services that support clients in their efforts to restore, improve, and/or preserve interpersonal and independent living skills and to access community support systems that support recovery and enhance resiliency. 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 assist the client in developing a personal community support system to substitute for the program's supportive environment and to minimize the risk of hospitalization and enhance the capability of independent living upon discharge from the program. The program will also provide a therapeutic environment which clients are supported in their efforts to acquire and apply interpersonal and independent living skills.

Service Components (State Plan Amendment)

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

- Assessment

- Plan Development
- Therapy
- Rehabilitation
- Collateral

Frequency and Requirements of Documentation (State Contract)

For Adult Residential Treatment, progress notes must be completed weekly 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 crisis residential treatment services, psychiatric inpatient hospital services, psychiatric health facility services, or psychiatric nursing facility services are reimbursed, except on the day of admission.

- 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))

C R I S I S R E S I D E N T I A L T R E A T M E N T S E R V I C E S

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 includes a range of

activities and services that support clients in their efforts to restore, improve, and/or preserve interpersonal and independent living skills, and to access community support systems. The service is available 24 hours a day, seven days a week and structured day and evening services are available all seven days. The timing, frequency, and duration of the various types of services provided to each client receiving Crisis Residential Treatment services will depend on the acuity and individual needs of each client.

Service Components (State Plan Amendment)

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

- Assessment
- Plan Development
- Therapy
- Rehabilitation
- Collateral
- 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 inpatient hospital services, psychiatric health facility services, or psychiatric nursing facility services.

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 night time 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 including one or more of the following: psychiatric, psychosocial, and counseling services, psychiatric nursing services, social services, and rehabilitative services provided in a psychiatric health facility licensed by the Department of Social Services. Psychiatric health facilities are licensed to provide acute inpatient psychiatric treatment to individuals with major mental disorders.

Services are provided in a psychiatric health facility under a multidisciplinary model. 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
- Plan Development
- Therapy
- Rehabilitation
- Collateral
- 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. Have an inpatient "included" diagnosis from the most current ICD code set. (See http://file.lacounty.gov/SDSInter/dmh/1076802_InpatientMedi-CalIncludedICD10DxCodes.pdf)
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(j)(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. 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 Countywide Resource Management Program (CRM) and the CRM Program 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 only under 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.

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 5

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