July 2013

COUNTY OF SAN DIEGO

INPATIENT OPERATIONS HANDBOOK FOR CHILD AND ADOLESCENT PSYCHIATRY SERVICES (CAPS)

A version of this handbook can be found on the OPTUM website at https://www.optumhealthsandiego.com/orgpublicdocs

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Note: Contractor shall utilize the Organizational Provider Operations Handbook (OPOH) for procedures that are not specific to inpatient care. This Inpatient Operations Handbook for CAPS shall serve as an addendum to the OPOH for inpatient specific information.

GENERAL OVERVIEW

This Handbook is designed to provide Rady Children and Adolescent Psychiatry Service (CAPS) Hospital with information related to the provision of inpatient hospitalization services for children and adolescent youth for Medi-Cal and uninsured indigent beneficiaries who are residents of San Diego County.

County of San Diego Behavioral Health Services (BHS), as the State contracted Mental Health Plan (MHP) for the County of San Diego, has entered into a contractual agreement with Rady CAPS as a Short-Doyle/Medi-Cal Hospital to provide inpatient psychiatric services to children and adolescents up to the age of eighteen years old.

CAPS shall include psychiatric inpatient services and routine physical hospital services. Psychiatric inpatient services are provided to patients who meet criteria with acute symptoms, patients who need Administrative Days for placement, and patients who are no longer acute, but are determined to require treatment as it relates to safety matters by medical staff. Rady CAPS will conduct the Utilization Review process and San Diego County MHP will assume the role of the point of authorization (POA) as noted in Title 9, Section 1820.215 (2)(A). In this role as the POA, the MHP provides payment authorization for children and adolescent Medi-Cal inpatient services and service categorization for unfunded patients.

This Handbook is part of the CAPS Statement of Work (SOW) and includes information on acute inpatient services, the Emergency Screening Unit (ESU), beneficiary rights for all patients as well as utilization review requirements for Medi-Cal and unfunded patients. Contractor shall utilize the Organizational Provider Operations Handbook (OPOH) for procedures that are not specific to inpatient care. This Inpatient Operations Handbook for CAPS shall serve as an addendum to the OPOH for inpatient specific information.

As a contracted provider CAPS is required to follow all State, Federal, and County regulations and policies for all San Diego County Medi-Cal patients as well as uninsured indigent beneficiaries who are residents of San Diego County. Medi-Cal patients from counties other than San Diego may also be treated at Rady CAPS (SB785). Providers of services for the Mental Health Plan (MHP) of San Diego are governed by the requirements of Title 9, Chapter 11 of the California Code of Regulations, referred to in this document as Title 9.

Rady CAPS is a Lanterman Petris-Short (LPS) designated facility and as such shall also comply with Welfare and Institutions Code, Chapter 2 Involuntary Treatment, and SD County LPS Designation Facility Guidelines. In addition CAPS shall work collaboratively with the County of San Diego Behavioral Health (CoSDBHS) designated Patient Advocate to ensure that all patients' rights are respected.

SHORT DOYLE/MEDI-CAL HOSPITAL

Rady CAPS is a Short Doyle/Medi-Cal hospital and as such shall follow regulations in Title 9, notably sections 1820.215 (2), 1820.220. CAPS will enter billing into Anasazi once POA has authorized appropriate days for reimbursement.

CoSDBHS is reimbursed for services provided by CAPS by the State through Short Doyle/Medi-Cal funding. The County may deem it appropriate for CAPS to continue to provide services to patients who no longer meet medical necessity criteria for Medi-Cal reimbursement.

TARGET POPULATION

Children and adolescent patients up to the age of eighteen may include, but are not limited to, the following groups: children, youth, including involuntary and voluntary per various state codes (Welfare and Institutions Code 5585 et seq. and 6552 et seq., etc.); acute and State Hospital populations; children and adolescents who are the responsibility of the County (Child Welfare Services or Probation Department); uninsured indigent patients; Medi-Cal eligible patients; and developmentally disabled patients needing acute psychiatric treatment. Acuity is associated with a patient being suicidal, homicidal or gravely disabled as part of meeting medical necessity. Refer to Medical Necessity Criteria on page 13.

RADY CAPS AND COUNTY OF SAN DIEGO BEHAVIORAL HEALTH ROLES

Rady CAPS:

Rady CAPS administration shall be responsible to ensure that the contract program is in compliance at all times with the County contract including the SOW, the CAPS Inpatient Handbook and with Utilization Review requirements, as well as all relevant State and Federal Regulations.

Rady CAPS shall ensure patients' rights in accordance with State and Federal Regulations, and County policy. Violations of patients' rights will be responded to appropriately and timely.

Rady CAPs is responsible for determining if patient meets admission criteria and reassessing patient's involuntary status determining if retention or reversal of 5150 is appropriate at admission.

The Rady CAPS program shall be responsible for performing ongoing quality review monitoring and quality assurance activities in compliance with JCAHO standards and County requirements.

The Utilization Review Committee shall be a Rady CAPS program committee designated for the purpose of reviewing clinical records for accuracy, quality of care, documentation standards, and inter-rater reliability on all Medi-Cal and unfunded admissions, continued stays, and adverse decisions.

County of San Diego:

The Children Youth and Families Contracting Officers Technical Representative (COTR), ESU, and the Quality Management Unit of Behavioral Health Services will programmatically monitor RADY CAPS program services.

The County Contract BHS Fiscal Unit performs administrative fiscal monitoring.

The CoSDBHS Quality Management Unit is responsible to oversee Rady CAPS Utilization Review. Final authorization for billing services to Medi-Cal will be based on designated Payment Authorization Agents decision as to meeting medical necessity.

The CoSDBHS representatives shall have access to clinical records and files, subject to State and Federal laws governing confidentiality. CoSDBHS CYF COTR and Quality Management staff evaluate contract performance and compliance with the contract requirements including, but not limited to, the utilization review requirements, the Federal Code of Regulations, the California Code of Regulations, and related policies and procedures.

EMERGENCY SCREENING UNIT (ESU)

Crisis consultation assessment and stabilization services for children and adolescents are operated through the County's Emergency Screening Unit (ESU) services seven (7) days a week, 24 hours per day. All referrals to CAPS are arranged through the ESU. Providers for children and adolescents should notify ESU regarding potential admissions prior to hospitalization by calling 619-421-6900.

ESU is responsible for the initial screening and referral to Rady CAPS for further evaluation of medical necessity. ESU facilitates direct admits from hospital emergency departments (ED), PERT, police, probation, etc. Rady CAPS shall work collaboratively with ESU during the admission process. ESU is responsible for monitoring bed usage especially during times of high census to ensure acute patients are served appropriately.

BENEFICIARY RIGHTS

San Diego County Mental Health is committed to protecting patients' rights in accordance with State and Federal Regulations and County policy. Violations of patients' rights will be responded to appropriately. Rady CAPs shall work collaboratively with the CoSDBHS designated Patient Advocate to ensure that all patients' rights are respected.

Confidentiality

Maintaining the confidentiality of patient and caregiver information is of vital importance, not only to meet legal mandates, but also as a fundamental trust inherent in the sensitive nature of the services provided through the MHP.

Lanterman Petris Short Act (LPS)

Rady CAPS has been designated as a County of San Diego inpatient psychiatric hospital Lanterman-Petris-Short (LPS) facility. As a LPS facility, Rady CAPS will adhere to the most current LPS Designation Guidelines and Processes for Facilities within San Diego County which is available in the County's Technical Resource Library. http://www.sdcounty.ca.gov/hhsa/programs/bhs/mental_health_services_act/technical_resource_library.html or by contacting QIMatters.hhsa@sdcounty.ca.gov.

Client Guide

Provider shall offer each patient and caregiver as appropriate the Client Guide at the patient's admission and upon request and document this activity in medical record. The guide is entitled: County of San Diego, Guide to Medi-Cal Mental Health Services. This beneficiary guide contains a description of the services available through the MHP, a description of the required process for obtaining services, a description of the MHP problem resolution process, including the complaint resolution and grievance and appeal processes and a description of the beneficiary's right to request a State fair hearing. Guides are written by County Quality Management Department and distributed by the MHP. Additional copies may be obtained by calling (619) 563-2700.

All patients and caregivers shall be offered a copy of the State Handbook, "Rights for Individuals in Mental Health Facilities", from State Department of Health Care Services and documenting this activity in medical record. The handbook deals with rights of persons both voluntarily and involuntarily admitted, discussing the role of the Patient Rights Advocate, rights that cannot be denied, rights that can be denied with good cause, medical treatment and the right to refuse it, and informed consent for medication.

The County MHS contracts with a Patient Advocacy Program to assist patients with grievances and appeals. The Patient Advocate Program distributes an informing brochure for patients called "Seclusion & Restraint: Answers to Your Questions" when appropriate.

Patient Grievances and Appeals

Patients may contact the Patient Advocacy Program at 1-800-479-2233, if they are dissatisfied with any aspect of inpatient services they receive under the MHP. It is the provider's responsibility to inform patients regarding their right to file a grievance or an appeal to express dissatisfaction with MHP services without negative consequences of any kind. Providers are required by Title 9 to post Grievance and Appeal posters (in English, Spanish, Vietnamese, Arabic, and Tagalog) in a visible area to ensure patients are advised of their rights. Title 9 requires that all providers ensure that these brochures are available to both patients and provider staff without the need of a verbal or written request by the patient. Copies of the Grievance and Appeal posters and brochures may be obtained by contacting the MHP at (619) 563-2700. Inpatient providers are required by Title 9 to maintain a log in which all patient or caregiver concerns or grievances are entered. Concerns may be expressed verbally or in writing. The log shall include the following elements:

- Complainant's name
- Date the grievance was received
- Name of person logging the grievance
- Nature of the grievance
- Nature of the grievance resolution
- Date of resolution
- The MHP may request a copy of a provider's Grievance Log at any time.

Patient Right To Request A State Fair Hearing

Medi-Cal beneficiaries have the right to request a fair hearing any time before, during or within 90 days after the completion of the beneficiary problem resolution process, whether or not the patient uses the problem resolution process and whether or not the patient has received a Notice of Action. Providers are required to inform their patients or the patients' conservators/legal guardians of these rights.

Patient Right To Have An Advance Health Care Directive

All new patients shall be provided with the information regarding the right to have an Advance Health Care Directive at their first face-to-face contact for services and documenting activity in the medical record. This procedure applies to emancipated minors and patients 18 years and older. Generally, Advance Directives address how physical health care should be provided when an individual is incapacitated by a serious physical health care condition, such as a stroke or coma, and unable to make medical treatment decisions for themselves. The MHP provides an informational brochure on Advance Directives, available in the threshold languages, and copies may be obtained through the MHP by calling (619) 563-2700.

Patient Right to Translation Service Availability

According to Title 9, and Title IV, Civil Rights Act of 1964, interpreter services shall be available to patients and families in threshold and non-threshold languages if requested or if the need is determined to assist in the delivery of specialty mental health services. It is not the standard of practice to rely on family members for translation services. County contracted interpreter services are available to all patients and their families if Rady staff are unable to provide translation services. To access interpreter services, refer to OPOH, Section C- Accessing Services for instructions.

ADVISING

What is the minor's legal status?

Is this minor a ward/dependent? OR: Does this minor have a parent/guardian who is legally responsible?

A. Wards and Dependents:

1. If the minor is a Ward/Dependent:
   a. Age of minor is not a factor for wards/dependents—the process is the same, regardless of age.
   b. The minor will most likely be admitted pursuant to a 72-hour hold.

2. Before the end of the first day of admission to the facility:

   a. Contact the minor's dependency attorney to provide notice of the minor's admission, and to request that the attorney counsel the minor regarding voluntary treatment.

      i) The phone number to the Legal Dependency Group is: 619-795-1540
      ii) The person who answers the phone at the Legal Dependency Group can identify who the person's attorney is.

   b. If the dependency attorney cannot be reached, or does not return call before the end of caller's shift, contact the Patient Advocacy Program, during that same day, to provide notice of the minor's admission, and to request that a patient advocate counsel the minor regarding voluntary treatment.

      i) The phone number to the Patient Advocacy Program is: 619-282-1134. Patient advocates are available at this number Monday through Friday, 8:00 to 5:00.
      ii) If it is after business hours, including the weekend, Patient Advocacy Program Director can be reached at: 619-300-2222.

   c. It is key to contact the attorney/patient advocate early in the admission and prior to the end of the 72-hour hold.

3. When contacting the Legal Dependency Group attorney or the Patient Advocacy Program patient advocate to have the attorney or advocate counsel the minor regarding voluntary treatment, have the following form available:

   a. APPLICATION FOR APPROVAL OF A MINOR'S REQUEST FOR VOLUNTARY INPATIENT PSYCHIATRIC TREATMENT (W & I Code § 6552)

   b. When the minor speaks with the attorney or advocate, the attorney or advocate is advising the minor of the minor's right to accept treatment on a voluntary basis.

   If the dependent minor wants to stay at CAPS:

   i) If the minor, after speaking with the attorney or advocate, agrees to accept treatment on a voluntary basis, minor signs the Application.

      a) Fax the signed copy to the person (attorney or advocate) who advised the minor.

         - The fax number for Dependency Legal Group: 619-795-1068
         - The fax number for Patient Advocacy Program: 619-282-4885

      b) After the attorney or advocate receives the signed application via fax, the attorney or advocate will sign the second page of the Application, and fax the signed second page back to CAPS.

         - At this point, the minor's legal status is "voluntary."

   If the dependent minor does not want to stay at CAPS:

   i) If the minor, after speaking with the attorney or advocate, does not agree to accept treatment on a voluntary basis, no signatures are obtained from minor.
   ii) Minor should still be on a 72-hour hold.
   iii) By the end of the 72-hour hold, one of the following things needs to occur:

      a) The minor changes his/her mind and wants to stay on a voluntary basis, and, after speaking again with the attorney or advocate, agrees to accept treatment on a voluntary basis.
      b) The minor is discharged from CAPS.
      c) The physician evaluates the minor, determines that the minor meets the criterion for a 14-day hold, and all of the proper steps are taken to place the minor on a 14-day hold.

         - If the minor is placed on a 14-day hold, contact the court at that time (even if it is after hours, or on the weekend) in order to notify the court of the hold, and the need for a Certification Review Hearing.
         - The court clerk can be reached at: 619-450-7829.
         - If the minor is placed on a 14-day hold, there will be a court hearing within four days (unless the minor is discharged, or agrees to voluntary admission prior to the hearing)

B. Does minor have a parent/guardian who holds legal responsibility?

1. Has the parent consented to admission of the minor?

Where there is a parent/guardian who is legally responsible for the minor, and the parent has *not* consented to admission, the age of the minor does not matter for the following process:

   a. If the parent has *not* consented to admission, by the end of the 72-hour hold, one of the following things needs to occur:

      i) The minor is discharged from CAPS **OR**
      ii) The physician evaluates the minor, determines that the minor meets the criterion for a 14-day hold, and all of the proper steps are taken to place the minor on a 14-day hold.

a) If the minor is placed on a 14-day hold, contact the court at that time (even if it is after hours, or on the weekend) in order to notify the court of the hold and the need for a Certification Review Hearing.
b) The court clerk can be reached at: 619-450-7829.
c) If the minor is placed on a 14-day hold, there will be a court hearing within four days (unless the minor is discharged).

Where there is a parent/guardian who is legally responsible for the minor, and the parent *has* consented to admission, the age of the minor *does* matter for the following process regarding: Roger S. advisement:

a. Is the minor under 14 years old?

i) If the minor is under 14 years old, and his/her parents or legal guardian have consented to admission, he/she is not entitled to a certification review hearing or a Roger S. hearing.

- No need to call Patient Advocacy for advisement

b. Is the minor 14 years or older?

i) The right to a Roger S. hearing applies to minors who are 14 years or older, and whose parents/legal guardian, have consented to treatment.
ii) Once parental consent for admission has been obtained, the right to a Roger S. hearing is automatically triggered—unless the minor waives his/her right to a hearing, a hearing must be scheduled.
iii) Once parental consent for admission has been obtained, call the Patient Advocacy Program to request a Roger S. Advisement.

a) Before calling the Patient Advocacy Program, have the **WAIVER OF ADMINISTRATIVE HEARING FOR HOSPITALIZATION OF A MINOR** form available

- Write the name of the minor and the birth date of the minor at the top of the form

- Completed form is faxed to the Patient Advocacy Program, regardless if the minor wants a hearing or not.

b) The phone number for the Patient Advocacy Program is: 619-282-1134.
c) The fax number for the Patient Advocacy Program is: 619-282-4885

i) After the patient advocate speaks with the minor, the patient advocate will inform Rady staff whether the minor wants to proceed with his/her right to have a Roger S. Hearing, or whether the minor waives the right to his/her Roger S. Hearing

ii) If the minor wants to have a Roger S. Hearing, call the court that same day to request a Roger S. Hearing (even if it is after hours or the weekend).

a) The court clerk can be reached at: 619-450-7829

b) A Roger S. Hearing will occur within 5 days of advisement, unless the minor is discharged prior to the hearing.

iii) After the minor speaks with the patient advocate, fill out the **WAIVER OF ADMINISTRATIVE HEARING FOR HOSPITALIZATION OF A MINOR** form.

a) If the minor does not want a hearing:

- Staff fill out: **PART B: FOR WAIVERS COMPLETED WHEN THE MINOR'S RIGHT ADVISOR WAS NOT PRESENT**

- Minor fill out: **PART C: CERTIFICATION OF STATEMENT**

b) If the minor wants a hearing, sign the bottom, where it states: **Patient refused to sign. Patient wants a Roger S. Hearing.**

iv) Fax the **WAIVER OF ADMINISTRATIVE HEARING FOR HOSPITALIZAION OF A MINOR** form to Patient Advocacy at: 619-282-4885.

Right to a Writ Hearing

1. Patients may also have the right to a writ hearing.

   a. If you have any questions about writ hearings, please feel free to contact the Patient Advocacy Program at: 619-282-1134.

MEDICAL RECORD REQUIREMENTS

The Rady CAPS facility shall maintain compliance with the Federal Code of Regulations (CFR 42), the California Code of Regulations (Title 9), and the contract between San Diego County Mental Health Plan and the Department of Health Care Services. Each individual's medical record must include at least the following:

1) Identification data (i.e. name, age, date of birth, address, telephone number, Medi-Cal beneficiary number when applicable, date of admission, etc.)

2) Evaluation/assessment, both psychiatric and physical.

3) Five (5) axes diagnoses from the current edition of DSM.

4) Treatment Plan signed by patient and caregiver if available and psychiatrist within 72 hours of admission.

5) Name of medical staff member(s) responsible for individual's care.

6) Progress notes for each service provided shall summarize current symptoms, proposed interventions, patients' response to treatment and how it relates to the specific goals and objectives of the treatment plan.

7) Each record entry shall be dated and signed using appropriate titles.

8) Record entries must be legible.

9) Medical doctors must be clearly identified.

10) Unlicensed professional staff and medical student entries shall be co-signed. (Resident physicians do not require a co-signature).

11) All other pertinent health record information

12) Admission note and ongoing daily notes should demonstrate medical necessity for acute and admin inpatient care. (written by both MD's and clinical support staff)

13) Discharge summary entered and final approved into Anasazi within 7 days of discharge from CAPS.

UTILIZATION REVIEW REQUIREMENTS

The County of San Diego Health and Human Services Agency Behavioral Health Services Utilization Review Plan for the Rady Children's Hospital Child and Adolescent Psychiatry Service (RADY CAPS) is established in compliance with the authority of Federal laws and regulations, Joint Commission on Accreditation of Hospital Standards, State of California Department of Healthcare Services (DHCS), and in accordance with California Welfare and Institutions Code (W&I) as

well as the California Code of Regulations (CCR) Short-Doyle/Medi-Cal (SD/MC) Utilization Review Requirements and Procedures.

The RADY CAPS program is licensed by the State of California and is a County of San Diego designated Lanterman-Petris-Short (LPS) facility. RADY CAPS is a County contracted program that provides comprehensive acute psychiatric inpatient services for child and adolescent residents of San Diego County and out of county youth falling under SB785 who are in need of psychiatric care in a secure environment and who are authorized/referred to the RADY CAPS facility by the County of San Diego Behavioral Health designated authority (currently the County's Child and Adolescent Emergency Screening Unit (ESU)).

Purpose:

Utilization Review is an administrative responsibility required by contract and mandated by Federal and State law for the purpose of systematically monitoring the appropriateness and quality of admissions, continued stay and health services rendered to children and adolescents of a culturally diverse population within San Diego County.

Objectives:

The objectives of Rady CAPS Utilization Review process shall be:

- To perform utilization review for all children and adolescents receiving services at CAPS, at least twice per week and within 7 days in accordance with Federal and State laws and regulations.

- To ascertain medical necessity for acute level of care, quality of care, and appropriateness of health care services in accordance with Federal and State laws and regulations.

- To ensure that available resources, facilities, and services are being used efficiently and effectively.

- To identify factors that will lead to more efficient utilization of facilities or services.

Scope:

This utilization review requirement applies to all children and adolescents in the target population receiving mental health services in the RADY CAPS inpatient hospital. This requirement includes:

- **Acute Inpatient Care Days (Service Code 906**): Days that meet criteria for medical necessity for inpatient hospitalization and are eligible for reimbursement by Short Doyle/MediCal (SD/MC), Realignment, or other funding sources. See Medical Necessity criteria, page 11.

- **Administrative Days (Service Code 907**): Days the patient's stay at the inpatient facility (RADY CAPS) must be continued beyond the patient's need for acute care while waiting for placement at a lesser level of care treatment facility (only applicable to MediCal beneficiaries). See Administrative Days criteria, page 13.

- **Non-Medically Necessary Hospital Days (Service Code 904**): Days the voluntary patient stays that continue beyond the acute phase for health and safety of the patient due to extenuating circumstances. Of these non-billable days, Rady is tasked with identifying those which are categorized as "justified" clearly documenting that safety concerns continue to necessitate inpatient care.
    - Justified Days: Voluntary days that do not meet criteria for medical necessity for Medi-Cal but are clearly documented to show patient continues to need inpatient treatment. Rady will mark these days as "justified" to help differentiate from non-justified days. The County recognizes that patients may need more care than Medi-Cal will reimburse. See Justified Days- Reasons Attachment 4
    - Non-Justified Days: Voluntary days where documentation does not clearly outline active behaviors that place the patient at risk. CAPS shall continue to work towards minimizing non-justified days.

Utilization Review Process:

Rady CAPS shall designate a clinical staff to conduct utilization review. Clinical staff must be licensed in the State of California as either a Registered Nurse, Licensed Clinical Social Worker, Marriage and Family Therapist, or a Licensed Clinical Psychologist. This designated UR staff must be familiar with inpatient medical necessity regulations detailed in Title 9, Section1820.205.

UR designee shall conduct utilization review for inpatient days for all Medi-Cal and unfunded patients at least two times per week. The UR designee shall compile the UR record on all patients and submit a Payment Authorization Request (PAR) on all Medi-Cal and unfunded patients to the County MHP designee. The County MHP designee or Point of Authorization (POA) will review and authorize appropriate days requested. Authorized days will be recorded on the Inpatient Payment Authorization (IPA) form and returned back to Rady CAPS for billing entry. Rady CAPS will not enter services into Anasazi until the IPA has been returned with approval for authorized/admin/unauthorized days. Upon receipt of the IPA, Rady has 5 business days to enter appropriate billing codes into Anasazi. This process shall be followed for all patients.

Utilization Review Designee Restrictions:

Code of Federal Regulations, Title 42, Subchapter C, Subpart D, Sections 456.206

No person having a financial interest in any mental health hospital may serve as the UR designee.

Utilization Review Record Shall Include:

1) Identification of the patient.
2) The name of the patient's physician.
3) The dates of admission and discharge.
4) Assessment and basis of determination of acute medical necessity for admission.
5) The plan of care is signed by patient and caregiver when available and licensed MD (non-licensed MD require co-signature) within 72 hours of admit, required under CFR 456.180.
6) Initial and subsequent continued stay review dates described under CRF 456.233 and 456.234.
7) Justification and plan for continued stay for each inpatient day, if the attending physician believes continued stay is necessary
8) Multiuse Complete Feedback Loop (copy of McFloop**)** when one has been generated.
9) Other supporting materials that the UR designee believes appropriate to be included in the record.
10) Payment Authorization Request Form completed with type of day requested- (acute, administrative, non-medically necessary).

Mental Health Plan's Point Of Authorization

The County of San Diego's Mental Health Plan's designee is responsible for authorization of acute and administrative days requested by Rady CAPS UR designee for all patients however only Medi-Cal patients are submitted for reimbursement from the State.

Utilization Review Records Kept by Mental Health Plan Point of Authorization

Code of Federal Regulations, Title 42, Subchapter C, Subpart D, Sections 456.211 (a-g);
California Code of Regulations, Title IX, Chapter 11, Section 1820.210.

The County of San Diego's Mental Health Plan will retain utilization records, requests for payment and payment authorizations on all Medi-Cal patients. UR records shall also be retained on all unfunded patients.

UTILIZATION MANAGEMENT

The County shall pay compensation for services performed to Rady CAPS monthly upon the County's receipt and approval of the properly completed claim and cost report forms for the period. Refer to OPOH for additional information regarding claims and billing.

Rady CAPS shall conform to Federal, State, and County regulations.

Rady CAPS is to maintain complete and adequate records to support utilization of CAPS services that comply with the requirements of Title 9 of the State of California Code of Regulations.

Objectives:

The objectives of Rady CAPS Utilization Management processes shall be to:

- To ascertain medical necessity, level of care, quality of care, and appropriateness of health care services are in accordance with Federal and State laws and regulations.

- To ensure that available resources, facilities, and services are being used efficiently and effectively.

CRITICAL CARE COMMITTEE MEETING

Purpose

The Critical Care Committee (CCC) reviews treatment cases at CAPS that involve a variety of serious complications, including but not limited to: repeated admissions, very dangerous behavior to self or others, discharge disposition problems, and inter-agency involvement. The committee also reviews quality of care issues, CAPS census data, significant changes in CAPS staffing and/or structure, contract compliance, and any topic of importance that concerns the County of San Diego and/or CAPS regarding the CAPS contract and services.

Composition

The Critical Care Committee may be composed of the Supervising Psychiatrist of the HHSA, the Program Manager of the County of San Diego Emergency Screening Unit, the County of San Diego COTR or designee for the CAPS program, Child Welfare Services Representative, and the County of San Diego UR/QI Specialist assigned as MHP's Point of Authorization to CAPS utilization review.
CAPS staff include: the Attending Psychiatrists, the Nurse Manager, and the Primary Clinicians (social workers), and UR designee.

Process

The CCC is held monthly and chaired by the ESU Program Manager, who provides Minutes from the previous meeting. The meeting is somewhat informal; members bring up topics for discussion and the chair ensures orderly discussion. The primary focus is clinical in nature focusing on significant problems related to specific patients. However, contract issues and quality of care issues are discussed as needed.

The County UR/QI Specialist (POA) is responsible to bring to the meeting updated Summary data from the ***Utilization Review Log***, and to verbally provide information gleaned from the data about trends in census, percentages of acute and non-billable days, etc. Copies of the Summary from the ***UR Log*** are provided to all the committee members at the meeting.

NOTE: The ***Utilization Review Log*** is sent as an attachment via email to the COTR and the ESU Program Manager a minimum of three days prior to the monthly CCC meeting.

MEDICAL NECESSITY CRITERIA

Admissions:

An initial and continued stay utilization review will be set for each admission within seventy-two hours after admission and by at least each seven days thereafter. In addition, each day's entries in the patient's medical record will be monitored for adherence for acute medical necessity criteria, or administrative day criteria if applicable.

The beneficiary shall meet medical necessity criteria as set forth in Title 9 Section 1820.205, Subsections (a)(1)-(2) below:

1. One of the following diagnoses in the Diagnostic and Statistical Manual of Mental Disorders, Current Edition, DSM- published by the American Psychiatric Association:

   - Pervasive Developmental Disorders
   - Disruptive Behavior and Attention Deficit Disorders
   - Feeding and Eating Disorders of Infancy or Early Childhood
   - Tic Disorders
   - Elimination Disorders
   - Other Disorders of Infancy, Childhood, or Adolescence
   - Cognitive Disorders (only Dementias with Delusions, or Depressed Mood)
   - Substance Induced Disorders, only with Psychotic, Mood, or Anxiety Disorder
   - Schizophrenia and Other Psychotic Disorders
   - Mood Disorders
   - Anxiety Disorders
   - Somatoform Disorders
   - Dissociative Disorders
   - Eating Disorders
   - Intermittent Explosive Disorder
   - Pyromania
   - Adjustment Disorders
   - Personality Disorders

2. Both the following criteria for medical necessity must be met:

   - Cannot be safely treated at a lower level of care, except that a beneficiary 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
   - Requires psychiatric inpatient hospital services, as the result of a mental disorder, due to the indications in either Subsection (a)(2)(B)1. or 2. below:

     a) Has symptoms or behaviors due to a mental disorder that (one of the following):
        1) Represent a current danger to self or others, or significant property destruction.
        2) Prevent the beneficiary from providing for, or utilizing, food, clothing or shelter.
        3) Present a severe risk to the beneficiary's physical health.
        4) Represent a recent, significant deterioration in ability to function.

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

Continued Stay:

Code of Federal Regulations, Title 42, Subchapter C, Subpart D, Sections 456.211; 231-236

The URC has developed interpretive guidelines to assess medical necessity, admission criteria, continued stay criteria, and discharge criteria as follows as outlined in Attachment 4. The committee bases its assignment of the initial continued stay review date on the seventy two hours after admission, and every seven days thereafter. The necessity for Continued Stay Days is based upon the individual's condition as defined below:

The beneficiary shall meet medical necessity criteria as set forth in Title 9 Section 1820.205, Subsections (a)(1)-(2) below:

1. One of the following diagnoses in the Diagnostic and Statistical Manual of Mental Disorders, DSM, current edition, published by the American Psychiatric Association:

   - Pervasive Developmental Disorders
   - Disruptive Behavior and Attention Deficit Disorders
   - Feeding and Eating Disorders of Infancy or Early Childhood
   - Tic Disorders
   - Elimination Disorders
   - Other Disorders of Infancy, Childhood, or Adolescence
   - Cognitive Disorders (only Dementias with Delusions, or Depressed Mood)
   - Substance Induced Disorders, only with Psychotic, Mood, or Anxiety
   - Disorder
   - Schizophrenia and Other Psychotic Disorders
   - Mood Disorders
   - Anxiety Disorders
   - Somatoform Disorders
   - Dissociative Disorders
   - Eating Disorders
   - Intermittent Explosive Disorder
   - Pyromania
   - Adjustment Disorders
   - Personality Disorders

2. Both the following criteria:

   a. Cannot be safely treated at a lower level of care, except that a beneficiary 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 Subsection (a)(2)(B)1 or 2 below:

      1) Has symptoms or behaviors due to a mental disorder that (one of the following):

         - Represent a current danger to self or others, or significant property destruction.
         - Prevent the beneficiary from providing for, or utilizing, food, clothing or shelter.
         - Present a severe risk to the beneficiary's physical health.
         - Represent a recent, significant deterioration in ability to function.

      2) Require admission for one of the following:

         - Further psychiatric evaluation.
         - Medication treatment.
         - Other treatment that can reasonably be provided only if the patient is hospitalized.

      3) Serious adverse reaction to medications, procedures or therapies requiring continued hospitalization.

      4) Presence of new indications that meet medical necessity criteria specified in above in (a).

      5) Need for continued medical evaluation or treatment that can only be provided if the beneficiary remains in a hospital.

Short-Doyle Medi-Cal Administrative Days Policy:

"Administrative Day Services" means psychiatric inpatient hospital services provided to only a Medi-Cal beneficiary who has been admitted to the hospital for acute psychiatric inpatient hospital services, and the beneficiary's stay at the hospital must be continued beyond the beneficiary's need for acute psychiatric inpatient hospital services due to a temporary lack of residential placement options at appropriate, non-acute treatment facilities.

Rady CAPS Social Worker (SW) shall initiate and document timely discussion with placing agency representative and ensure that required weekly outreach to placements are being done and problem solving with placing agency if necessary. Any exceptions shall be communicated to ESU PM and COTR immediately to avoid non-funded days. Additionally, Rady CAPS shall work with placing agency and caregiver to ensure timely exploration of realistic residential options to facilitate prompt discharge from inpatient, ESU PM and COTR shall be informed when prolonged utilization of admin days is occurring as it creates system wide capacity issues.

Rady CAPS SW will inform ESU and UR designee of request for Admin Days. The process is documented daily in the patient's record of need for placement. CAPS SW will notify placing agency regarding need for weekly submission of contacts. The contact sheet completed by the placing agency is submitted to Rady CAPS SW and then forwarded by the SW to ESU and the UR designee to be attached to the UR record.

Requests for Point of Authorization 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 Point of Authorization:

1. During the hospital stay, a beneficiary previously has met medical necessity criteria for reimbursement of acute psychiatric inpatient hospital services.

2. There is no appropriate, non-acute treatment facility in a reasonable geographic area and the medical record maintains documentation of contacts with a minimum of five appropriate, non-acute treatment facilities per week subject to the following requirements:

   a) 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 (see attachment 3.1 below) Exceptions are on a case by case basis and shall be approved by COTR or designee.

   b) 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:

      - The status of the placement option
      - Name and Title of person contacted.
      - Date of the contact
      - Signature of the person making the contact.

If a patient ends up being discharged home or to Polinsky Children's Center or contact sheets are not turned in an appropriate timeframe then Administrative Days are converted back to Non-billable days.

Determination of Funding:

Responsibility of payor for mental health services rendered is determined by financial eligibility and the Payment Authorization Request.

Financial Eligibility is determined prior to admission for care, if possible, or at the time of admission. A written eligibility inquiry is completed by the responsible RADY CAPS staff. All patients shall be UMDAPed at admission. Patients shall also be checked for Medi-Cal eligibility on admission, at the first of each month during the stay (if applicable), and at discharge. Short Doyle/Medi-Cal must be used prior to realignment funds if the patient is eligible. Responsible RADY CAPS staff shall also explore whether an unfunded patient may be eligible for Medi-Cal and help facilitate that process. Realignment funding is the funding of last resort and cannot be used until all other resources are exhausted. Funding may be shifted from one source of funding to another as financial eligibility or the condition of the patient changes, or when the patient or patient's representative does not identify the patient as eligible to receive benefits and the eligibility is later discovered. RADY CAPS staff is also responsible for entering or updating the Demographics form in Anasazi during this time. This process also applies to out of county (SB785) patients being treated at CAPS.

Performance of Payment Authorization:

California Code of Regulations, Title 9, Chapter 11, Section 1820.215(a)(2)(A).
Inpatient Hospital Services

a. Payment Authorization Process-–The County of San Diego's POA Utilization Specialists perform payment authorization in accordance with the California Code of Regulations, Title 9, Chapter 11, Section1820.215(a)(2)(A). All reviews are conducted by a qualified and licensed reviewer and all determinations must be adequately supported by documented clinical evidence.

b. Oversight—The County of San Diego's Mental Health Plan is responsible for oversight of the payment authorization process.

c. Payment Authorization is a retrospective payment authorization process.

Level of Care Changes:

When the patient is determined to no longer meet medical necessity criteria, the level of care changes from medically necessary (acute) to either non-medically necessary or administrative days. The non-medically necessary or administrative day level of care can return to the acute level of care if the need for acute care and medical necessity criteria can be justified and documented in the patient's record. All acute and non-medically necessary levels of care are determined retroactively upon review by the UR Specialist through Rady UR process.

The exacerbation of symptoms is not considered a new episode. The patient's acute care status is restored on the date the exacerbation is determined.

Payment Authorization Request (PAR) Form:

Code of Federal Regulations, Title 42, Subchapter C, Subpart D, Section 456.211;
California Code of Regulations, Title 9, Chapter 11, Section 1820.220(c)(2)

RADY CAPS informs the RADY UR Specialist of each child's admission, funding source, and discharge. The PAR is completed after the patient is discharged within a maximum of 4 calendar days following patient's discharge. The PAR contains identifying information (name, age, sex, birth date, medical record number); legal status on admission; date of admission; funding source; recipient's physician; diagnosis on admission and a summary of the days the patient was hospitalized The number of acute or admin days requested with supporting documentation and the Payment Request Agent's signature, complete the PAR process. The RADY UR Specialist then submits the PAR to the County MH Plan's Point of Authorization who will review the PAR and return with authorized acute and admin days to the CAPS Medical Record Technician to enter into the County's billing system. CAPS staff enters service codes into Anasazi within 5 business days of return of IPA from County. This process also applies to out of county (SB785) patients being treated at CAPS.

Final Payment Authorization and Timeline:

Code of Federal Regulations, Title 42, Subchapter C, Subpart D, Sections 456.237-238;
California Code of Regulations, Title 9, Chapter 11, Section 1820.210

If the entire stay does not appear to be medically necessary, the case will be reviewed by the POA after the child is discharged. Decisions for approval or denial of days shall be made not more than 14 (fourteen) calendar days after submission to the POA. A summary of patient days and denials may be discussed at the Utilization Management or Critical Care meeting.

The patient's assignment shall be opened to Rady CAP's unit and subunit on the day of admission and closed on the day of discharge. The opening and closing of the unit/subunit is a critical function that has a fiscal impact on the rest of the system of care. Rady administration shall monitor this task daily to ensure compliance with this important process.

Discharge Planning:

The Rady CAPS facility shall develop and maintain a written discharge planning procedure that provides for early initiation of such planning in order to begin discharge planning on the day the patient is admitted. Discharge planning should achieve placement at the lowest level of care reasonable in relation to health and safety. UR shall assess the current status of discharge plans, including availability of alternate placements. If Rady CAPS learns that a patient's previous placement is at risk, Rady CAPS will initiate the possibility of administrative days immediately by following the Administrative Days process. Active discharge planning shall be documented daily for each patient. Discharge Summaries are also to be completed in Anasazi within seven days of closing of the assignment as required per contract.

CONFIDENTIALITY OF MEDICAL RECORDS

Code of Federal Regulations, Title 45, Subtitle A, Subchapter C, Parts 160 &164

Rady CAPS must keep all records confidential and shall only disclose minutes and records in accordance with applicable state and federal laws. They shall be made available for County of San Diego, State Department of Health Care Services and State Department of Health Services inspection upon request, as well as relevant federal agencies. In addition, copies of reports and records must be available to Committee members, county, state, and federal surveyors.

AUDITS

As a contracted facility, Rady CAPS is subject to the same audit process as a County operated facility would be. In addition, Rady CAPS is subject to State and Federal Audits as a provider of Short Doyle/Medi-Cal services. In addition, QI may request charts of patients for review of documentation of medical necessity and quality of care.

MEDICAL CARE EVALUATION (MCE)

Code of Federal Regulations, Title 42, Subchapter C, Subpart D, Sections 456.241-243

Medical Care Evaluation Studies shall be conducted for quality improvement and reported by the Rady CAPS URC for analysis and recommended changes. At least one study shall be completed annually and at least one study shall be in progress at all times. Samples drawn for study purposes will represent a mix of Short Doyle/Medi-Cal and realignment funds patients, as well as patients with other sources of funding. The method used to select shall be the high volume, or high risk and /or problem prone children and adolescents. Analysis may be directed towards admissions, durations of stay, ancillary services furnished including drugs and biologicals, and professional services performed in the hospital.

The results of the MCE studies and how the results have been used to make changes to improve the quality of and promote a more effective and efficient use of facilities and services shall be documented and presented in the form of a report. The report will contain documentation of the analyzed data quarterly and at the end of each study. These quarterly reports on the MCE are presented at the URC mtg which is held at least quarterly. Documentation that actions have been taken to correct or investigate further any deficiencies or problems in the review process and recommendations of more effective and efficient hospital care procedures will be provided by the responsible RADY CAPS staff.

MCE REPORTING SCHEDULE

MCE study information is reported to Utilization Review Committee (URC) members.

JANUARY	MCE oral update on Final Report from previous year
APRIL	MCE Final Report due from previous FY and New MCE Proposal for current FY due
JULY	MCE Update
OCTOBER	MCE Update

UTILIZATION REVIEW COMMITTEE (URC)

Code of Federal Regulations, Title 42, Subchapter C, Subpart D, Sections 456.150-245
California Code of Regulations, Title 9, Chapter 11, Section 1820.210

The Utilization Review Committee (URC) at RADY CAPS is a multi-disciplinary team, representing a cross-section of personnel delivering services to children and adolescents. The URC is responsible to ensure that utilization review (see above) is performed in accordance with all State and Federal regulations and requirements. The URC accomplishes this task by reviewing a sample of current Medi-Cal and unfunded admissions. Records are reviewed for quality issues and adherence to regulations regarding medical necessity for continued stay. Charts for review are selected the morning of the URC and submitted to the CAPS business manager one hour prior to URC begin time. UR designee selects a sample of current Medi-Cal and unfunded charts based on the day's current census. Generally, half of the Medi-Cal charts are selected and half of the unfunded charts are selected with approximately a total of 5-6 charts selected for the URC's review. The chart is either reviewed for its admission day or a continued stay day, being the day before the URC day, When it is determined that patient no longer meets medical necessity, a McFloop will be completed and added to the URC minutes. The URC shall not be utilized as the MHPs payment authorization process, which shall be through the POA.

The URC is composed of two physicians who are board certified in child psychiatry, both of whom are knowledgeable in diagnosis and treatment of mental disease; two social workers; one psychologist; and two registered nurses. The URC may meet monthly, but at least quarterly or as directed by MHP's COTR. The URC elects a chairperson from among its members. A quorum, defined as a simple majority of the total number of members that includes at least two physicians, is required to make URC decisions. The chairperson conducts the URC meetings, approves and signs all minutes and correspondence.

Rady URC is required to keep updated on State and Federal regulations as well as keeping up on current documentation standards.

The Mental Health Plan's UR/QI staff will attend the URC. County staff may provide updates on State and Federal regulations, feedback on adherence to regulations in the medical records, review of any or all medical records that may demonstrate problems, and do trainings as necessary.

URC Minutes:

Code of Federal Regulations, Title 42, Subchapter C, Subpart D, Sections 456.212(a)

Minutes and records shall be maintained for three years. The original of the URC minutes and all attachments shall be kept on file in the RADY CAPS administrative offices. The minutes shall include:

- Name of Committee.
- Location, date and duration of meeting.
- Names of members present and absent by discipline.
- Description of activities.
- The number of cases reviewed, including recommendations and follow-up as appropriate.
- Patient name, patient number and medical record number.
- Period of time reviewed.
- Medical Care Evaluation (MCE) studies completed or in progress of completion.
- Signature and date of the Chairperson indicating review and approval of the minutes.

Code of Federal Regulations, Title 42, Subchapter C, Subpart D, Sections 456.206

No person having a financial interest in any mental health hospital may serve as a member of the Utilization Review Committee. A Utilization Review Committee member may not review records of a patient for whom the member is directly responsible for care.

Records and Reports Kept by the URC:

Code of Federal Regulations, Title 42, Subchapter C, Subpart D, Sections 456.212(a)

a. **Medical Care Evaluation Study (MCE)** projects are intended to annually investigate either serious existing or potential service delivery problems. This is accomplished by using a research design consisting of predetermined document screening criteria, valid sampling techniques, analysis of findings, and recommendations for corrective action, if necessary.

b. **Multi-Use Complete Feedback Loops (McFloops)** are issued as a form of peer review to physicians and primary clinicians where there is a failure to adhere to regulations or lack of appropriate documentation in the clinical record to justify medical necessity. The form details the particular problem or issue and may or may not request a resolution or explanation. The feedback loop may also be used for a record after discharge only for URC inter-rater reliability purposes, completed by UR designee.

c. **URC Meeting Minutes**

Distribution to Individuals of Records and Reports:

Code of Federal Regulations, Title 42, Subchapter C, Subpart D, Sections 456.212(b);
California Code of Regulations, Title IX, Chapter 11, Section 1820.220 (a).

a. Minutes are distributed to each member during the URC meeting. A copy is also distributed to the Mental Health Plan's Point of Authorization.

b. Medical Care Evaluation Study reports are distributed to all members at the URC meetings. The Medical Care Evaluation Committee may also distribute reports as determined by that committee. A copy is also distributed to the Mental Health Plan's Point of Authorization.

c. Feedback loops and completed Payment Authorization Requests are not distributed, but summarized and documented in the minutes. Review of these records is on a 'need to know' basis.

d. Summary of URC minutes without private health information (PHI) is submitted to the COTR within 14 calendar days of meeting highlighting any risk and compliance issues and plan to mitigate.

Confidentiality Of Records And Reports

Code of Federal Regulations, Title 42, Subchapter C, Subpart D, Section 456.213
Code of Federal Regulations, Title 45, Subtitle A, Subchapter C, Parts 160 & 164.

All records and reports that may identify a particular patient use a medical record number identifier rather than a name, and will comply with all Health Insurance Portability and Accountability Act of 1996 requirements.

REPORTS REQUIRED

All LPS facilities are required by the State DHCS to submit the following quarterly reports to County Behavioral Health Services Quality Management Unit, using the State forms included in the Appendix:

- Denial of Rights/Seclusion and Restraint (MH 308)—if there are no instances of denied rights in a quarter, hospitals must submit a report saying this. (Attachment 6)
-
- Quarterly Report on Involuntary Detentions (MH 3825) –not required for non LPS facilities (Attachment 7)
- Convulsive Treatment Administered—to include Outpatient ECTs.

These reports should be submitted to the QI Unit by the 15th day after the end of the quarter on the forms have been provided, both in hard copy and electronically.

In addition to the above reports required, Contractor shall also submit:

- MONTHLY STATUS REPORTS (MSR) - Contractor shall submit a complete and accurate Monthly Status Report (MSR) by the fifteenth (15th) of the following month to the Behavioral Health Contract Administration Unit and COTR group. Format and content of the MSR shall be as directed by CYF. Compliance shall be measured by completeness, accuracy, and timeliness. See COTR Analyst for copy of CAPS MSR if needed.

Please note that because of HIPAA confidentiality requirements completed forms containing patient identifiers are not allowed to be electronically submitted in a non-secure manner. These reports can be mailed or faxed to the QI Unit confidential fax at (619)236-1953.

DEFINITIONS

Acute Days: Medically necessary hospital inpatient days eligible for reimbursement by Short Doyle/MediCal (SD/MC), Realignment, or other funding sources.

Administrative Days: The days the patient's stay at the acute inpatient facility (RADY CAPS) must be continued beyond the patient's need for acute care while waiting for placement at a lesser level of care treatment facility.

Admission Review: A review and decision process performed by the Reviewer to determine the medical necessity and appropriateness of admission to an inpatient level of care.

Assessment: A formal, documented evaluation or analysis of the cause or the nature of the eligible patient's mental, emotional, or behavioral disorder. The assessment service is limited to an intake examination, mental status evaluation, physical examination, and laboratory testing necessary for the evaluation and treatment of the eligible patient's mental health needs.

Attending Physician: The physician primarily responsible for the care of the patient, including the development of the treatment plan, documentation of medical necessity, and discharge planning.

Exacerbation: A significant worsening of symptoms after a relatively stabilized and/or improved state requiring a change from non-acute to an acute level of care.

Feedback Loop: See McFloop

Inpatient Payment Authorization (IPA): A written form specified by the Mental Health Plan to approve or deny inpatient Short-Doyle/Medi-Cal payment.

Level of Care (LOC): The type and intensity of patient services necessary for effective treatment of persons with mental disorders.

Licensed Clinical Social Worker (LCSW): A person possessing a valid license to practice as a clinical social worker granted by the California State Board of Behavioral Science Examiners.

Licensed Vocational Nurse (LVN): A person possessing a valid license to practice vocational nursing granted by the California Board of Vocational Nurse and Psychiatric Technician Examiners.

Marriage and Family Therapist (MFT): A person possessing a valid license to practice as a marriage and family therapist granted by the California State Board of Behavioral Science Examiners.

McFloop: The Multiuse Complete Feedback Loop is issued by the Utilization Review Specialist and/or the Utilization Review Committee as a form of peer review to physicians and primary clinicians where there is a failure to adhere to regulations or lack of appropriate documentation in the clinical record. A feedback loop is a form that details what the particular problem is and asks for a resolution or explanation. The Utilization Review Committee or committee designee issues the feedback loop to the clinician only when the child is in-house. The clinician returns the feedback loop with requested information as soon as possible and under no circumstances are changes to a closed record requested. A feedback loop may be used for a record after discharge only for Utilization Review Committee inter-rater reliability purposes.

Medical Care Evaluation (MCE) Study: A study that is intended to investigate serious existing or potential service delivery problems. This is accomplished by using a research design consisting of predetermined document screening criteria, valid sampling techniques, analysis of findings, and recommendations for corrective action, if necessary.

Medicaid: The federal and state program that provides federal reimbursement to states for the costs of medical care for the poor and disabled.

Medi-Cal: California's Medicaid Program is called Medi-Cal.

Medical Necessity: Acute inpatient mental health services are covered benefits of realignment and Medi-Cal Programs when:

1. An individual, as a result of a suspected or established diagnosis of mental disorder, poses substantial jeopardy to self or society.
2. An individual, as a result of a suspected or established diagnosis of mental disorder, exhibits confusion, impaired judgment, or uncooperative behavior to the extent diagnostic procedures and treatment could not reasonably be assured at a lower level of care.
3. Criteria are specifically detailed in the California Code of Regulations, Title 9, Chapter 11, Section 1820.205.

Non-Medically Necessary Hospital Stay (Non-Acute / Administrative): A hospital stay that continues beyond the acute phase for health and safety of the patient due to uncontrollable circumstances.

Payment Authorization Agent: The person responsible for providing retrospective payment authorization on all discharged records to determine the approved acute days and administrative days.

Payment Authorization Request: (PAR): A written form completed by RADY CAPS requesting inpatient Short-Doyle/Medi-Cal payment for acute or administrative days for each patient.

Beneficiary: Any person certified as eligible under the Medi-Cal Program according to Section 51001. Title 22, California Code of Regulations.

Consolidation: The term used by the state to describe shifting Medicaid dollars to the local (County) level for capitation and distribution.

Contract Hospital: A provider of psychiatric inpatient hospital services, which is certified by the State Department of Health Services, and has a contract with a specific Mental Health Plan to provide Medi-Cal psychiatric inpatient hospital services to eligible beneficiaries.

County of Beneficiary: The county which currently is responsible for determining eligibility for Medi-Cal applicants or beneficiaries in accordance with Section 50120. Title 22, California Code of Regulations.

Fee For Service Medi-Cal (FFS/MC): California's Medi-Cal program that provides reimbursement on a per procedure basis for a broad array of health and limited mental health services provided to individuals who are eligible for Medi-Cal.

Fiscal Intermediary: The entity which has contracted with the State Department of Health Services to perform services for the Medi-Cal program pursuant to Section 14104.3 of the Welfare and Institutions Code.

Gatekeeper: Term for an organizational function which:

- Coordinates and assesses patient services needs
- Monitors services rendered to assure that only needed services are provided
- Identifies health practices and behaviors of target populations
- Creates a fixed point of responsibility
- Reduces service overlap and redundancy

Hospital: An institution, including a psychiatric health facility, that meets the requirements of Section 51207, Title 22, California Code of Regulations.

Implementation Plan for Psychiatric Inpatient Hospital Services: A written description submitted to the State Department of Health Care Services (DHCS) by the Mental Health Plan (MHP), and approved by the DHCS, which specifies the procedures which will be used by a prospective MHP to provide psychiatric inpatient hospital services.

Inpatient Hospital Services: See Psychiatric Inpatient Hospital Services definition.

Lanterman-Petris-Short (LPS): Persons designated by San Diego County who may take or cause to be taken, mentally disordered person(s) into custody and place him/her in a facility designated by the County and approved by the State DHCS as a Facility for 72-hour Treatment and Evaluation.

Local Mental Health Care Plan (PLAN): The term used to denote the local managed mental health care plan administrator. The Plans will be responsible for offering an array of mental health services to all eligible Medi-Cal beneficiaries.

Managed Care: A new paradigm funding approach that combines clinical services and administrative methods in an integrated and coordinated way to provide timely access to care in a cost effective manner. Emphasis on prevention and early care reduce usage of more expensive methods of treatment.

Medically Necessary: A service or treatment that is appropriate and consistent with diagnosis, and that, in accordance with accepted standards of practice in the mental health community of the area in which the health services are rendered, could not have been omitted without adversely affecting the member's condition or the quality of care rendered.

Mental Health Carve Out: It has been determined at the state level that the local County Mental Health Departments will design and develop a managed mental health care system separate from the local County Departments of Health. However, a clear mental health and health interface for integrating service delivery must be included in the design.

Mental Health Plan (MHP): An entity which enters into an agreement with the State DHCS to provide beneficiaries with psychiatric inpatient hospital services. An MHP may be a county, counties acting jointly or another governmental or non-governmental entity.

MHP Authorization for Payment: The initial process in which reimbursement for services provided by an acute psychiatric inpatient hospital to a beneficiary is authorized in writing by the MHP. In addition to the MHP authorization for payment, the claim must meet additional Medi-Cal requirements prior to payment.

Provider: A hospital, whether a Fee For Service/Medi-Cal or a Short Doyle/Medi-Cal provider, which provides psychiatric inpatient hospital services to beneficiaries.

Psychiatric Inpatient Hospital Services: Both acute psychiatric inpatient hospital services and administrative day services provided in a general acute care hospital, a free standing psychiatric hospital or a psychiatric health facility that is certified as a hospital. A free standing psychiatric hospital or psychiatric health facility that is larger than sixteen (16) beds may only be reimbursed for beneficiaries 65 years of age and over and for persons under 21 years of age. If the person was receiving such services prior to his/her twenty-first birthday and he/she continues without interruption to require and receive such services, the eligibility for services continues to the date he/she no longer requires such services or, if earlier, his/her twenty second birthday.

Primary Diagnosis: The diagnosis that is the focus of the current episode of treatment and is determined to be the reason for admission. The diagnosis must be consistent with the criteria specifically detailed in the California Code of Regulations, Title 9, Chapter 11, Section 1820.205.

Psychiatric Technician (PT): A person possessing a valid license to practice psychiatric nursing granted by the California Board of Vocational Nursing and Psychiatric Technician Examiners.

Psychiatrist: A person possessing a valid license as a Physician and Surgeon from the Medical Board of California along with evidence of completion of the required course of graduate psychiatric education as specified by the American Board of Psychiatry and Neurology in a program of training accredited by the American Medical Association or the American Osteopathic Association.

Psychologist: A person possessing a license to practice as a psychologist granted by the State Board of Psychology, Medical Board of California.

Quality Management Program Supervisor: A person who is responsible to supervise and coordinate all aspects of the Quality Management Program.

Quorum: A quorum is a simple majority of members of the Utilization Review Committee that includes at least two (2) physicians.

Realignment Funds: Funding by the State of California to provide mental health services for patients (or their representative) that have need but lack ability to pay for their services.

Registered Nurse (RN): A person possessing a valid license to practice as a registered nurse granted by the California Board of Registered Nursing.

Review: An evaluation and decision process by the Utilization Review Specialist/Coordinator for medical necessity, appropriateness of level of care, and intensity of professional mental health services provided.

Reviewer: A person authorized to review medical records for the purpose of performing Utilization Review. Authorized persons are the Quality Management Program Supervisor and Utilization Review/Quality Management (UR/QI)Specialists.

Short Doyle/Medi-Cal: Mental health insurance funded by the State of California and the Federal government for patients determined eligible by Social Services.

Utilization Record: A record compiled by the Reviewer which includes the Inpatient Payment Authorization, PAR, UR Worksheets and completed McFloop forms.

MENTAL HEALTH WEBSITES

The following websites can be accessed for additional information:

County of San Diego, Health & Human Services Agency:
http://www.co.san-diego.ca.us

State of California Department of Mental Health:
http://www.dmh.ca.gov

Medi-Cal Website:
http://www.Medi-Cal.ca.gov

Optum Health San Diego:
https://www.optumhealthsandiego.com

Network of Care:
http://networkofcare.org/home.cfm

State of California Office of Patient Advocate:
http://www.opa.ca.gov

State of California Department of Managed Health Care:
http://www.dmhc.ca.gov

National Alliance of Mentally Ill:
http://www.nami.org

Healthy Families:
http://www.healthyfamilies.ca.gov

ARC of San Diego
http://www.arc-sd.com

Family & Youth RoundTable
http://www.fyrt.org/

Attachment 1 –

Admission Criteria

For Medi-Cal reimbursement for an admission to a psychiatric inpatient hospital, the beneficiary shall meet medical necessity criteria set forth in 1 and 2 below.

1. One of the following diagnoses in the Diagnostic and Statistical Manual, current edition, published by the American Psychiatric Association:
   a. Pervasive Developmental Disorders
   b. Disruptive Behavior and Attention Deficit Disorders
   c. Feeding and Eating Disorders of Infancy or Early Childhood
   d. Tic Disorders
   e. Elimination Disorders
   f. Other Disorders of Infancy, Childhood, or Adolescence
   g. Cognitive Disorders (only Dementias with Delusions, or Depressed Mood)
   h. Substance Induced Disorders, only with Psychotic, Mood, or Anxiety Disorder
   i. Schizophrenia and other Psychotic Disorders
   j. Mood Disorders
   k. Anxiety Disorders
   l. Somatoform Disorders
   m. Dissociative Disorders
   n. Eating Disorders
   o. Intermittent Explosive Disorder
   p. Pyromania
   q. Adjustment Disorders
   r. Personality Disorders

2. A beneficiary must have both a and b:

   a. Cannot be safely treated at a lower level of care; 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 of one of the following:

         a) Represent a current danger to self or others, or significant property destruction
         b) Prevent the beneficiary from providing for, or utilizing food, clothing, or shelter
         c) Present a severe risk to the beneficiary'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 be reasonably provided only if the patient is hospitalized.

For day of admission, acuity is met by meeting above criteria and will be claimed as Acute Inpatient Care Days (Service Code 906). If acuity is not met at admission, the entire inpatient stay is claimed as Non-Medically Necessary Hospital Days (Service Code 904).

Attachment 2 –
Continued Stay Criteria

Continued stay services in a psychiatric inpatient hospital shall only be reimbursed when a beneficiary experiences one of the following:

1. Continued presence of indicators that meet the medical necessity criteria as specified in Attachment 1.
2. Serious adverse reaction to medications, procedures or therapies requiring continued hospitalization.
3. Presence of new indicators that meet medical necessity criteria specified in Attachment 1.
4. Need for continued medical evaluation or treatment that can only be provided if the beneficiary remains in a psychiatric inpatient hospital.

An acute patient shall be considered stable when no deterioration of the patient's condition is likely, within reasonable medical probability, to result from or occur during the transfer of the patient from the hospital.

When continued stay criteria is met, it is claimed using Acute Inpatient Care Day (Service Code 906).

<u>Short-Doyle Medi-Cal Administrative Days Policy</u>

"Administrative Day Services" means psychiatric inpatient hospital services provided to a Medi-Cal beneficiary who has been admitted to the hospital for acute psychiatric inpatient hospital services and the beneficiary's stay at the hospital must be continued beyond the beneficiary's need for acute psychiatric inpatient hospital services due to a temporary lack of residential placement options at appropriate, non-acute treatment facilities.

Requests for Point of Authorization payment authorization for administrative day services shall be approved by the 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 Point of Authorization:

1) During the hospital stay, a beneficiary previously has met medical necessity criteria for reimbursement of acute psychiatric inpatient hospital services.

2) There is no appropriate, non-acute treatment facility in a reasonable geographic area and the medical record maintains documentation of contacts with a minimum of five appropriate, non-acute treatment facilities per week subject to the following requirements:

c) 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 (see attachment 3.1 below)

d) 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:

I. The status of the placement option
II. Date of the contact
III. Signature of the person making the contact.

When Administrative Day criteria is met, days are claimed using Administrative Days (Service Code 907).

Attachment 4-

County of San Diego
WEEKLY DISCHARGE PLANNING UPDATE
(week indicated will be Monday thru Sunday)

Patient Name:__________________________________**for Week of:**___________________

Lead Placing Agency:____

The following contacts have been made this week:

1. Facility / Program Name: Staff name contacted:
   _________________________________ _______________________________________
   Telephone number:_________________________ Date contacted:__________________________
   ☐ Bed available now ☐ No bed available at this time ☐ Will not consider

2. Facility / Program Name: Staff name contacted:
   _________________________________ _______________________________________
   Telephone number:________________________ Date contacted:________________________
   ☐ Bed available now ☐ No bed available at this time ☐ Will not consider

3. Facility / Program Name: Staff name contacted:
   _________________________________ _______________________________________
   Telephone number:________________________ Date contacted:__________________________
   ☐ Bed available now ☐ No bed available at this time ☐ Will not consider

4. Facility / Program Name: Staff name contacted:
   _________________________________ _______________________________________
   Telephone number:_________________________ Date contacted:_________________________
   ☐ Bed available now ☐ No bed available at this time ☐ Will not consider

5. Facility / Program Name: Staff name contacted:
   _________________________________ _______________________________________
   Telephone number:_________________________ Date contacted:_________________________
   ☐ Bed available now ☐ No bed available at this time ☐ Will not consider

Signature of staff making telephone calls:____

PLEASE FAX COMPLETED FORM TO CAPS SOCIAL WORKER AT: 858-966-8164 FAX
858-966-8145 PHONE #

JUSTIFIED DAYS- REASONS

Attachment 5-

All Non-Medically Necessary Hospital Days (Service Code 904) will be subjected to the criteria of justified days. It is the intent of the County to justify any days that do not meet medical necessity for Medi-Cal, but are still seen as justified for further hospitalization. Days will be justified when documentation supports it. If CAPS feels that a client needs justified days that cannot be documented according to County QI standards of medical necessity, CAPS may call ESU manager/COTR designee to ask for exception. Approvals for the extended stay will be communicated to all involved parties as well as the reason for the approval, and the time limitations for the approval. The expectation is that CAPS clinicians will continue to document current symptoms, behaviors, med changes, etc., that are used to determine the justified days. Also, communication with ESU manager/COTR designee is only when clinical documentation cannot justify the days that the staff at CAPS feel is needed for the patient. Requesting days from ESU/COTR shall be an exception.

McFloops will only be given when a patient no longer meets medical necessity, and the days are not justified. “Justified” days will not be a part of the McFloop process. CAPS will inform COTR and ESU manager of any patient who has accrued four days of non billable/non justified days.

(A) Suicidal Ideation present but with no plan, no clear intent- Self Injurious behaviors including eating disorders. Consider reason for admission, lethality of suicide attempt, history of suicide attempts (or significant repeated admits within a short amount of time)

(B) No discharge disposition- hospital cannot discharge because there is no reasonable place for patient and patient is not eligible for Admin days. County approves this reason.

(C) Psychotic- MD unable to assess patient, active psychotic symptoms not under control yet with meds. Symptoms disabling enough that they cannot be treated outpatient.

(D) Gravely Disabled- Would met acuity if in adult inpatient. Cannot sustain functioning without assistance from staff (i.e feeding, hygiene) clearly documented by staff. This could also potentially include dually diagnosed kids who have not returned to normal functioning.

(E) Danger to others- Still may be unpredictable, had recent serious assault (reason for admission).

(F) Other- Significant medication changes, physical health symptoms/tests that require monitoring. Must specify/describe reason. Medication dosages/titration clearly documented.

SAN DIEGO COUNTY CHILDREN'S MENTAL HEALTH SERVICES
CHILD & ADOLESCENT MEDICAL NECESSITY ACUITY CRITERIA
INTERPRETIVE GUIDELINES

MEDICAL NECESSITY ACUITY CRITERIA	ADMISSION CRITERIA	CONTINUED STAY CRITERIA	DISCHARGE CRITERIA
Danger to self	Active and current suicidal threats or behavior may include extreme forms of self-mutilation or harm.	Remains suicidal with intent and plan; on suicide precautions; less restrictive level of care not possible. Intensive services needed, intrusiveness and pervasiveness of the suicidality intent and plan present, other risk factors in evidence.	Patient can contract for safety or symptoms can be managed at less restrictive level of care even though patient may continue to feel hopeless, helpless, or have suicidal ideation.
Danger to others/destruction of property.	Active violent or destructive behavior which presents imminent risk to others or property.	Active violent or destructive behavior with continued imminent risks to others or property present.	Behaviors no longer endangering others or destructive to property; threatening behaviors can be managed at a less restrictive level of care.
Unable to utilize food, shelter or clothing.	Inability to perform age appropriate self-care skills, unable to use food, shelter, or clothing in a way that meets basic needs.	Self care skills performed only with intensive assistance from facility staff.	Able to perform age appropriate self care with prompting; able to utilize food, shelter, and clothing to meet basic needs.
Presents a severe risk to the beneficiary's physical health.	Physical health severely jeopardized due to inability to care for self.	Physical health managed only with health care team's intensive interventions and direction.	Physical health can be managed at a less restrictive level of care.
Recent and dramatic deterioration in ability to function.	Demonstrable absence of, or severely compromised, ability to function.	Remains unable to function without intensive staff supervision or secure setting.	Able to function at less restrictive level of care.

DENIAL OF RIGHTS/SECLUSION AND RESTRAINT MONTHLY REPORT

(See Instructions on Reverse Side)

Month:

Year:

Facility: Program/Ward: County:

Name, Title and Telephone Number Of Person Preparing Report: Date of Report:

A	B	C Number of Days Denied Each Right or Days in Seclusion/Restraint									
Patient's I.D.	No. of Days In Facility	1	2	3	4	5	6	7	8	9	10
D Total No. of Patients in 1-10											

ONLY THE FOLLOWING RIGHTS MAY BE DENIED FOR GOOD CAUSE:

1. Right to wear one's own personal possessions WIC 5325 (a)
2. Right to keep & use one's own personal possessions WIC 5325 (a)
3. Right to keep and be allowed to spend a reasonable sum of one's own money for canteen expenses and small purchases WIC 5325
4. Right to have access to individual storage space for one's private use WIC 5325 (c)
5. Right to see visitors each day WIC 5325 (d)
6. Right to have reasonable access to telephones, both to make and receive confidential calls or to have such calls made for them WIC 5325 (d)
7. Right to have ready access to letter writing materials, including stamps WIC 5325 (e)
8. Right to mail and receive unopened correspondence WIC 5325 (f)

RESTRICTIONS IMPOSED

9. Seclusions (isolation of an involuntary patient in a locked room)
10. Restraints (any physical device used to immobilize the patient because of behavioral problems.)

INSTRUCTIONS FOR DHCS 1804

COLUMN A: Patients of Hospital Number

Each patient who has been denied a right or place in seclusion/restraint by the facility during the reporting month must be listed on this form by the I.D. or hospital number.

COLUMN B: Number of Days in Facility This Month

Enter each patient's total days in the facility for the month.

COLUMN C: Number of Days Denied Each Eight or Days in Seclusion/Restraint

Enter in Columns 1 through 10 the number of days each patient was denied a right or in seclusion/restraint.

COLUMN D: Totals-Numbers of Patients Denied Each Right

Enter in Column D, the total number of patients denied each right or placed in seclusion/restraints.

(Do not count the numbers in the boxes to achieve Column D as the number of patients, not days, is needed.)

RESTRICTIONS IMPOSED

Seclusion and restraints MUST be reported and documented because these actions imply the denial of other specific patient's right, such as the right to access to the telephone.

These implied denials need not be documented in the patients chart and should not be reported on this form.

When the exercise of a particular right is specifically requested by the patients, however, and denied by the staff while the patient is in restraint or seclusion, the denial of this right MUST be documented by the staff while the patient is in restraint of seclusion, the denial of this right MUST be documented in the patient's record and reported on this form.

SUBMIT TO: The local mental health director, or your county or state hospital executive director, by the tenth of the following month.

Attach all DHCS 1804 Denial of Rights/Seclusions—Monthly Report to this form.

QUARTERLY REPORT ON INVOLUNTARY DETENTIONS

County Name:
County Code:

			Year
Quarter 1	☐	July 1 to Sept. 30	_____
Quarter 2	☐	Oct. 1 to Dec. 31	_____
Quarter 3	☐	Jan. 1 to March 31	_____
Quarter 4	☐	April 1 to June 30	_____

SUMMARY OF INVOLUNTARY DETENTIONS IN COUNTY DESIGNATED FACILITIES
(excluding State Hospitals)

Provider Code	Facility Name	72-Hr. Eval & Treatment		14-Day Intensive Treatment	Additional 14-Day Intens.Treat (Suicidal)	30-Day Intensive Treatment	180-Day Post Certification
		Child/Adol (0-17 Yrs)	Adult (18 & Up)				

The above information is required by the California Welfare and Institutions Code (WIC) Section 5402(a).
The information provided in this quarterly report will be incorporated into an annual report as required by WIC Section 5402(d). ***Please see the next page or reverse side for Reporting Instructions***. **This quarterly report should be submitted by the 30th of the month following the end of each quarter via email, fax, or U.S. Mail.** If you need assistance preparing this report, please send an email to one of the persons below.

Fax Number: **(916) 552-8555**

Email Address: bryan.fisher@dhcs.ca.gov or kenneth.lee@dhcs.ca.gov

Mailing Address: **DEPARTMENT OF HEALTH CARE SERVICES**
Research and Analytic Studies Branch, MS1200
P.O. BOX 997413
SACRAMENTO, CA 95899-7413

DATE	CONTACT PERSON	PHONE NUMBER

REPORTING INSTRUCTIONS:

SPECIAL INSTRUCTIONS: This reporting applies to all instances of involuntary treatment regardless of funding source. That is, persons who are treated involuntarily in private psychiatric facilities or whose treatment is funded by private resources must be reported along with persons whose treatment is funded through Medi-Cal or the county mental health program. **Do not count persons who are referred to another county for services. It is the responsibility of the county in which a treatment facility is located to include all of the information about the facility in its report.**

If there are no designated facilities, public or private, within your county in which at least one person was admitted involuntarily for evaluation and treatment, you must still submit this report on a quarterly basis with zero counts in each of the boxes provided. For example: In the "Facility Name" box enter "NO FACILITY", and zero fill each of the six treatment categories.

For each private or public facility reported, completely fill out each category of Involuntary Detention. Do not leave any section blank. If there are no counts for a specific category, please enter a zero count. Please include a telephone number of the county contact for data verification purposes.

Please use one form to report each quarter.

PROVIDER CODE: Enter the provider code for the facility assigned for the Cost Reporting System. If the facility is not a Short-Doyle provider, then leave blank.

FACILITY NAME: Enter the names of all facilities, public or private, designated by the county to which at least one person was admitted involuntarily for 72-hour evaluation and treatment, 14-day intensive treatment, Additional 14-day intensive treatment (Suicidal), 30-day intensive treatment, or 180-day post certification during the reporting period. **Exclude State Hospitals for the Mentally Disabled from the list of designated facilities.** These are being reported by the State Hospitals.

Note: A person who initially is admitted to a unit within a facility and is subsequently transferred to another unit within the same facility or to another facility for the same treatment episode while being held under the same Welfare & Institutions (WIC) section is to be counted only once. This person is to be counted in the unit or facility where each specific detention was initiated. This is to eliminate duplicate reporting.

72-HOUR EVALUATION AND TREATMENT: Enter the total count of persons admitted to the county-designated facility for 72-hour treatment and evaluation under WIC Section 5150, 5170, 5200, 5225, and 5585.55 during the report quarter. If the same person was admitted more than once during the quarter for 72-hour evaluation and treatment, count each admission. The number of persons reported should be separated into two groups, children and adolescents (0-17 years old) in one and adults (18 years & over) in the other as indicated.

14-DAY INTENSIVE TREATMENT: Enter the total count of persons certified during the report quarter for 14 day intensive treatment under WIC Section 5250.

ADDITIONAL 14-DAY INTENSIVE TREATMENT (SUICIDAL): Enter the total count of persons certified during the report quarter for an additional 14-days intensive treatment due to suicidal tendencies under WIC Section 5260. If the same person is involuntarily detained for a 14-day certification more than once during the quarter, count each certification.

30-DAY INTENSIVE TREATMENT: Enter the total count of persons certified during the report quarter for an additional period of intensive treatment of not more than 30 days under WIC Section 5270.15 for gravely disabled mentally disordered individuals who are unable to sufficiently stabilize within the 14-day period of intensive treatment.

180-DAY POST-CERTIFICATION: Enter the total count of persons certified during the report quarter for 180 days additional treatment under WIC Section 5303 and 5304.