County of San Diego
Health & Human Services Agency
Behavioral Health Services (BHS)

INPATIENT OPERATIONS HANDBOOK

Adult/Older Adult (A/OA) &

Children Youth and Families (CYF)

System of Care

Revised July 2020

LIVE WELL SAN DIEGO

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

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OVERVIEW

This Inpatient Operations Handbook is designed to provide County of San Diego Behavioral Health Services (BHS) contracted Medi-Cal inpatient providers with information related to the provision of managed care services for Medi-Cal beneficiaries who are residents of San Diego County. The San Diego County Mental Health Medi-Cal Managed Care Inpatient Consolidation consists of County and contractor-operated services. Included is information on emergency services, acute inpatient services for Medi-Cal clients, and acute and long-term residential services for Medi-Cal and Realignment funded clients. Please note that providers of services for the Mental Health Plan 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. Website address to obtain Title 9, Chapter 11 of the California Code of Regulations, referred to in this document as Title 9 is: http://www.dhcs.ca.gov/services/mh

Since 1997, the County of San Diego's Health and Human Services Agency, Behavioral Health Services, the County of San Diego Mental Health Plan (MHP), has contracted with Optum (previously known as United Behavioral Health) to be the Administrative Service Organization (ASO) for the MHP. In their role as the ASO, Optum provides payment authorization and utilization management for Medi-Cal inpatient services.

The Optum Utilization Management (UM) staff consists of board-certified psychiatrists, licensed psychologists, Registered Nurses (RNs), Licensed Clinical Social Workers, Licensed Marriage and Family Therapists, and Licensed Professional Clinical Counselors. The Optum UM staff review all requests for authorization of payment for acute inpatient admissions for children and adolescents (excluding client's admission to Rady Child Adolescent Psychiatric Services (CAPS) hospital), adults and older adults for San Diego County Medi-Cal beneficiaries. A client's authorization for services is based on meeting the medical necessity criteria of Title 9 of the California Code of Regulations (Section 1830.205). In accordance with State requirements, a psychiatrist is involved in all decisions to deny, terminate or modify inpatient services.

The contact information for Optum is:

Telephone Number: **1-800-798-2254**
Mailing Address: **Optum**
PO Box 601370
San Diego, CA 92160-1370

Email: **With respect to client confidentiality, please do not send by email Protected Health Information (PHI)**. Email address for most Optum care managers are in the format of "first name. last name"@optum.com or may be obtained from the Care Manager directly.

Confidential Fax: **Utilization Management: 1-866-220-4495**
Provider Services Department: 1-877-309-4862

The **Optum Provider Line at 1-800-798-2254** is available during normal business hours, Monday thru Friday from 8:00 am to 5:00 p.m. to resolve provider issues, inquiries, and/or complaints.

The contact information for **County of San Diego Behavioral Health Administration** is:

Telephone Number: **619-563-2700**

Mailing Address: **P0 Box 85524, San Diego, CA 92186**
or 3255 Camino Del Rio South
San Diego, CA 92108-5524

Confidential Fax: **619-236-1953**

1. GENERAL GUIDELINES

Contracted inpatient providers are required to follow all Federal, State, and County regulations and policies for all San Diego County Medi-Cal beneficiaries.

Admissions should be based solely on the clinical review of the client's needs. Hospitals cannot require, as a condition of admission or acceptance of a transfer, that a patient voluntarily seeking mental health care first be placed on a 5150 hold. If the client meets Title 9 Medi-Cal medical necessity criteria, inpatient services should not be delayed because of an authorization of payment decision. A copy of the Title 9 medical necessity criteria is referenced in section 3B (p.7-8).

Pre-authorization is not required for emergency services, however, inpatient providers are required to notify Optum of all admissions.

County of San Diego Behavioral Health Services (BHS) contracted Medi-Cal inpatient providers shall maintain Lanterman Petris Short (LPS) designation.

2. NOTIFICATION PROCEDURES

Providers shall notify Optum of all admissions by calling Optum as soon as possible when the client has Medi-Cal as primary coverage. For clients who have Medi-Cal as a secondary coverage it is not necessary to notify Optum, unless the client has exhausted their primary insurance coverage and the primary insurance coverage is no longer available to pay for client's care.

To notify Optum of an admission contact the Optum Utilization Management (UM) Unit using the following numbers:

Optum Provider Line at **1-800-798-2254.**

In accordance with State and Federal Regulations, provider must notify Optum of emergency admissions within 10 days. Failure to do so may result in denial of payment.

3. AUTHORIZATION FOR REIMBURSEMENT OF ACUTE INPATIENT SERVICES

A. Authorization Process: A description of the process for requesting reimbursement authorization for admission to acute inpatient services is as follows:

- Authorizations for services are provided concurrently following the first day of admission, and are based on the written documentation from the hospital.

- The requesting hospital contacts Optum staff by calling 1-800-798-2254, option 3, to notify Optum that the requesting hospital is faxing clinical documentation to be reviewed and considered for reimbursement for acute services.

- If a request for authorization is considered to be incomplete, the request will be withdrawn. Optum will notify the provider of the incomplete submission and request that the provider resubmit with additional clinical information. Without a complete authorization request, determination to approve or deny authorization cannot be made. Without authorization approval services may not be billable.

- Based on information from this medical record review, the Optum staff must be able to determine if the client meets Title 9 medical necessity criteria in order to authorize reimbursement for services.

- The Optum staff will continue to review clinical documentation concurrently for all additional acute and administrative days requested for reimbursement.

- For cases in which the provider indicates, or the MHP determines, that following the standard procedure could jeopardize the life or health of the client, ability to attain, maintain, or regain maximum function, Optum will make an expedited authorization decision pursuant to the client's health condition need. Most standard authorization decisions are made within hours of a request, although by managed care regulation (CFR 42, 438.210 (d) (1)) the MHP has up to 14 days. In the case of an expedited authorization request most requests will be determined within 1-4 hours, but in accordance with regulations, no more than (three) 3 days.

B. Medi-Cal Medical Necessity Criteria

Title 9 of the California Code of Regulations (Section 1820.205) specifies the following medical necessity criteria for admission to inpatient services:

The client must meet one of the following diagnoses in the most current Diagnostic and Statistical Manual, published by the American Psychiatric Association:

- Pervasive Developmental Disorders
- Disruptive Behavior and Attention Deficit Disorders
- Feeding and Eating Disorders of Infancy or Early Childhood
- Elimination Disorders
- Other Disorders of Infancy, Childhood, or Adolescence
- Tic Disorders
- Elimination Disorders
- Cognitive Disorders (only Dementia 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, excluding Antisocial Personality Disorder

In addition to meeting diagnostic criteria listed in, the client **must meet both of the criteria** below:

1. 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
2. Requires psychiatric inpatient hospital services, as a result of a mental disorder, due to either (a) or (b) below:

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

    - Represents a current danger to self or others, or significant property destruction;

- Prevents the client from providing for, or utilizing, food, clothing or shelter;
- Presents a severe risk to the client's physical health;
- Represents a recent, significant deterioration in ability to function.

(b) Requires admission for treatment and/or observation for one of the following which cannot safely be provided at a lower level of care:

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

Note: Substance abuse disorder and developmental disorder in absence of other mental illness does not meet Title 9 medical necessity criteria for acute inpatient admission.

4. AUTHORIZATION FOR REIMBURSEMENT OF CONTINUED STAY IN ACUTE INPATIENT SERVICES

A. Authorization Process for Continued Stay: Concurrent Review

After the initial authorization, if a client continues to require acute care the provider must request an additional authorization for continued stay. To complete the authorization process for continued stay, the requesting hospital must submit clinical documentation that demonstrates the client continues to meet Medi-Cal Medical Necessity Criteria. The steps for additional authorization for continued stay is as follows:

- The requesting hospital contacts Optum Utilization Management (UM) staff to give notice that they will be faxing clinical documentation to be reviewed and considered for reimbursement for acute services.
- Based on the medical records review, Optum UM staff will determine if reimbursement will be authorized and will notify provider of the number of days authorized.
- As part of the concurrent review process, UM staff will also consider information regarding the client's discharge plan with the facility.
- At any time, the Optum UM staff may request additional documentation to determine medical necessity.

B. Criteria for a Client's Continued Stay

In order for Optum UM staff to authorize reimbursement for continued stay in acute inpatient services, the client must continue to meet the Medi-Cal Medical Necessity Criteria noted for admission to inpatient services (section 3B, p.7-8). Continued stay in an acute psychiatric inpatient hospital will only be reimbursed when a client experiences one of the following:

- Continued presence of admission reimbursement criteria indications for psychiatric inpatient hospital services as specified in Medi-Cal Medical Necessity Criteria;
- Serious adverse reaction to medications, procedures or therapies requiring continued hospitalization;
- Presence of new indications, which meet admission reimbursement criteria; and
- Need for continued medical evaluation or treatment that can only be provided if the client remains in an acute psychiatric inpatient hospital unit.
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C. Authorization for Concurrent Review

Decisions to approve, modify, or deny provider requests for authorization concurrent with the provision of SMHS to beneficiaries shall be communicated to the beneficiary's treating providers, including both the hospital and treating physician, in writing, within 24 hours of the decision. If the MHP denies or modifies the request for authorization, the MHP must notify the beneficiary's' treating providers, including both the hospital and treating physician, in writing, within 24 hours of the decision. If the MHP denies or modifies the request for authorization, the MHP must notify the beneficiary, in writing, of the adverse benefit determination. In the case of concurrent review, care shall not be discontinued until the beneficiary's treating provider(s) has been notified of the MHP's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the beneficiary. In cases where the MHP determines it will terminate, modify, or reduce services, the MHP must notify the beneficiary, in writing, of the adverse benefit determination prior to discontinuing services.

D. Emergency Admission Requirements

MHP's may not require prior authorization for an emergency admission for psychiatric inpatient hospitalization services or to a psychiatric health facility, whether the admission is voluntary or involuntary, and the beneficiary, 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. Upon notification by a hospital, MHPs shall authorize payment for out-of-network services when a beneficiary of the MHP, with an emergency psychiatric condition, is admitted to a hospital, or PHF, to receive psychiatric inpatient hospital services or PHF services. After the date of admission, hospitals must request authorization for continued stay services for the beneficiary subject to concurrent review by the MHP.

5. AUTHORIZATION FOR REIMBURSEMENT OF ADMINISTRATIVE DAYS

Administrative days are defined in Title 9 as psychiatric inpatient hospital care provided when the client's stay at the hospital must be continued beyond needed acute treatment days due to a temporary lack of placement options at appropriate, non-acute treatment facilities.

A. Authorization Process for Administrative Days

- The requesting hospital contacts Optum Utilization Management (UM) staff to notify Optum that the requesting hospital is faxing clinical documentation to be reviewed and considered for reimbursement for administrative days.
- The Optum UM staff conducts a concurrent review, assuring that the adult/older client is either on a waiting list for a Short Term Acute Residential Treatment (START), Skilled Nursing Facility (SNF), or Institution for Mental Disease (IMD) or that the hospital is actively seeking one of these placements.
- The Optum UM staff conducts a concurrent review, assuring that the children/adolescent, adult/older client is either on a waiting list for a Probation, Child Welfare Services, or San Diego and Imperial County Regional Center for the Developmentally Disabled or the hospital is actively seeking one of these placements.
- The expectation is that hospitals make calls to the Skilled Nursing Facilities on behalf of clients, even if they do not have funding in order to be eligible for administrative days retroactive

Note: For Regional Center consumers, psychiatric hospitals will be paid for administrative days by the Regional Center in accordance with written agreements with each hospital. Contact the Regional Center for a copy of the Working Agreement between the County of San Diego Mental Health Programs and Regional Center, October 2007, for additional information regarding visitation, placement search and other Regional Center responsibilities.

6. CRITERIA FOR ADMINISTRATIVE DAYS

San Diego County Mental Health policy regarding reimbursement for inpatient Administrative Days requires that clients meet the following criteria:

- Client must have been approved for at least one acute inpatient day prior to request for administrative days.
- Client no longer meets criteria for Acute Inpatient Treatment, and is awaiting placement at either a:

  a) Short Term Acute Residential Treatment (START) facility, or
  b) Skilled Nursing Facility (SNF), or
  c) Casa Pacifica, (a Short Term Transitional Residential Facility); or
  d) Has been accepted by the Long-Term Care Committee for placement in a facility that is paid for by the Mental Health Plan.

NOTE: This policy may be subject to change.
In addition to the above requirement, and in accordance with Title 9, in order to meet the State standards to receive reimbursement for administrative days, the provider is required to make and document at least one contact per day (except weekends and holidays), starting with the day the beneficiary is placed on administrative day status, with a minimum of five (5) contacts per week, with appropriate non-acute treatment facilities. The provider must contact a minimum of five (5) different facilities per week. Once five contacts have been made and documented, any remaining days within the seven consecutive day period from the day the beneficiary is placed on administrative day status can be authorized. A hospital may make more than one contact on any given day within the seven consecutive day period; however, the hospital will not receive authorization for the days in which a contact has not been made until and unless all five required contacts are completed and documented.

Adults and Older Adults:

a) START facilities (Optum is centralized contact, call 1-800-748-2254, option 3), or
b) Skilled Nursing Facilities (SNF), or
c) IMD

Children:

a) Probation, or
b) Project Oz or Cool Beds or
c) Child Welfare Services, or
d) San Diego and Imperial County Regional Center for the Developmentally Disabled.

The County may waive the requirement of five (5) different contacts per week if there are fewer than five (5) appropriate non-acute residential treatment facilities available as placement options for the beneficiary (IMDs, Casa Pacifica). The lack of appropriate, non-acute treatment facilities and the contacts made at appropriate facilities shall be documented to include the status of the placement, date of the contact, and the signature of the of the person making the contact. In no case shall there be less than one contact per week. Ongoing weekly documentation shall clearly support assessment of client for continued need of long-term placement. This documentation shall include but is not limited to:

- The status of the placement option
- Date of the contact
- Signature of the person making the contact
- Decision of inquiry (yes or no)

This documentation shall be sent by fax, on a weekly basis, to the Utilization Management Department, Optum Public Sector, San Diego (Overview section for Optum fax information).

In accordance with Title 9, in order to meet the State standards to receive reimbursement for administrative days, five (5) placement contacts per week are required from the placement agency and are to include the following required elements:

- name of facility
- date of contact
- person contacted
- immediate availability of bed
- name and signature of person making the call

Examples of appropriate placement status options include, but may not be limited to the following:

- The beneficiary's information packet is under review;
- An interview with the beneficiary has been scheduled for [date];
- No bed available at the non-acute treatment facility;
- The beneficiary has been put on a wait list;
- The beneficiary has been accepted and will be discharged to a facility on [date of discharge];
- The patient has been rejected from a facility due to [reason]; and/or,
- A conservator deems the facility to be inappropriate for placement.

This information shall be documented and referenced in the medical record.

Other issues regarding Administrative Days are:

- Authorization for payment for Administrative Days for those clients awaiting long term care placement will be made when the client is accepted for placement.

- Administrative Days may not be used for clients awaiting placement in a non-treatment program such as a Board and Care facility or Independent Living Facility.

- Authorization of payment for Administrative Days starts on the day following the last acute day authorized. Administrative Days end when the client is discharged from the inpatient setting, when the client enters the chosen facility, or when the client no longer meets criteria for admission to the facility based on level of care guidelines and medical necessity criteria. Administrative Days will also end if the discharge plan changes to a type of facility that is not one mentioned in section 6.

- In accordance with State regulations Administrative days are impacted if a client must be discharged to a medical/surgical unit for physical health care. Clients who have been authorized for administrative days and who are then discharged to a medical/surgical unit for physical health care, will not be approved for administrative days if they return to the acute psychiatric unit. However, if the client remains on the medical/surgical unit, the client may continue to meet the criteria for administrative days under their physical health plan and could be placed on administrative days on the physical health unit.

If a client's condition improves while they are waiting for placement at a facility, administrative days will be authorized up to the day the client no longer meets medical necessity criteria for admission to an approved type of facility as noted above.

7. OTHER AUTHORIZATION ISSUES

A. Electroconvulsive Therapy (ECT)

Inpatient ECT shall not require authorization. However, the client shall meet Title 9 medical necessity criteria for acute psychiatric inpatient treatment at admission. Inpatient providers are to maintain their own ECT Consulting Psychiatrists lists and provide their own consultants for ECT utilizing their Credentialing and Privileging guidelines. The ECT consult is Medi-Cal reimbursable and Optum authorizes payment to a network provider. See Appendix A for Procedure for Voluntary Electroconvulsive Treatment. The psychiatrist will need to attest to client's competence to treatment (see Appendix B).

Outpatient ECT shall require authorization. The psychiatrist requesting ECT shall complete the ECT Authorization Request and submit it to Optum Utilization Management (UM). If indications for ECT are present, up to 14 treatments over a 6-month period may be authorized. The total of 14 treatments shall include all inpatient treatments as well as outpatient treatments within a ninety-day period. ECT sessions beyond 14 shall be reviewed with the Optum Medical Director.

A course of convulsive treatment consists of several ECT treatments for which client's single written informed consent may apply. W & I Code Section 5326.7 (d) limits both the number of treatments and duration of the period (not exceeding 30 days) over which the treatments are administered to the individual designated in the informed consent. Additional treatments in number or time, not to exceed 30 days, shall require a renewed written informed consent.

Written informed consent shall be a requirement. Only the client may give that consent, unless a Superior Court determines that the client lacks capacity, in which case the Court shall appoint a responsible relative, guardian, or conservator to consider the consent. When a request for such a determination is to be made of the Superior Court, it is to be made by a petition for such a hearing, presenting evidence of incompetency and of the need for ECT, and accompanied by the completed form "Determination RE: Capacity to Give Written Informed Consent to Convulsive Treatment and Order."

Written informed consent requires that a person knowingly and intelligently, without duress or coercion, clearly and expressly communicates consent to the treating psychiatrist and in writing on the standard consent form. Twenty-four hours must pass after the explanation by the psychiatrist of potential risks and benefits of ECT before the consent form may be signed by the client. Written informed consent may be withdrawn by the client (or consenting party) verbally or written at any time prior to or between treatments.

Consent must be given in writing, and only on the standard consent form (DCHS 1800 (MH300)) prescribed by the State Department of Health Care Services (DHCS) supplemented by additional written information applicable to the particular client and course of convulsive treatment. Consent form DCHS 1800 (MH300) is available in English (Appendix D) and Spanish (Appendix D). While the conservator is among those to whom proposed convulsive treatment to a conservatee must be fully explained, the conservator lacks authority to consent to that treatment in the absence of a Superior Court determination that the client is incapable of giving consent.

At any time during the course of ECT treatment of a person who has been deemed incompetent, that person shall have the right to claim regained competency. Should he/she do so, the person's competency must be reevaluated, involving the client's attorney, the attending psychiatrist, and the Superior Court as delineated in W & I Code 5326.7.

For involuntary clients, state regulations require that a review committee of the clients' record by a committee of two (2) physicians, at least one of whom shall have personally examined the client. See Appendix E for Procedure for Involuntary Electroconvulsive Treatment. Involuntary ECT requires both physicians on the review committee to be in agreement with the treating psychiatrist (Appendix F). The

review committee will include one physician appointed by the treatment facility and one shall be appointed by the BHS Director (WIC 5326.7). The physician selected from the list of board-certified or board-eligible psychiatrists or neurologists is considered "appointed" by the BHS Director. It is the responsibility of each hospital to maintain a list of board-certified or board-eligible psychiatrists or neurologists approved by the Behavioral Health Services (BHS) Director to provide second opinions regarding suitability of ECT in involuntary situations. Candidate names for this list must be submitted to the BHS Clinical Director (Dr. Michael Krelstein), along with CVs, and once approved on behalf of the BHS Director the names will remain active so long as that physician remains a member in entirely good standing, without practice restrictions, at the applicable hospital. Additional names may be added from time to time, by submitting them to the BHS Clinical Director. An email receipt of approval will be considered sufficient evidence that approval has been obtained on behalf of the BHS Director.

BHS Clinical Director contact information is below:

Michael S. Krelstein, MD
Clinical Director, Behavioral Health Division
San Diego County, Health & Human Services Agency
3255 Camino Del Rio South
San Diego, CA 92108
Office: 619-563-2771
Fax: 619-563-2705
Email: michael.krelstein@sdcounty.ca.gov

Facilities may bill the County of San Diego for facilities charges associated with Outpatient ECT.

Invoices must include:

- Client name;
- Social Security Number and Date of Birth;
- Date of authorization for ECT;
- Total number of authorized units;
- Facility authorized for the procedure; and
- Name of the psychiatrist who administers the procedure.

Invoices may be sent to:

ATTENTION: Contracts Support Unit Analyst
San Diego County Mental Health Administration
PO Box 85524, San Diego, CA 92186
or 3255 Camino Del Rio South
San Diego, CA 92108-5524

B Referrals by the County's Emergency Psychiatric Unit (EPU)

All clients are screened for medical necessity criteria. The receiving facility must notify Optum upon the client's admission.

C Non-Acute Planned Admissions

Providers are required to contact Optum for authorization prior to planned admissions.

D Clients Under the Influence of Drugs or Alcohol: Authorization of Payment for Services

Optum clinicians shall authorize payment for one day of psychiatric inpatient hospital acute care for clients under the influence of drugs or alcohol, under the following circumstances:

- The client has a qualifying psychiatric diagnosis under Title 9 medical necessity criteria; and
- The clients' symptoms or behavior currently meet Title 9 medical necessity criteria for admission; and
- The client cannot be managed in a medical setting or at a lower level of care; and
- The client does not require a medical detoxification as determined by hospital medical staff;

Optum clinicians will conduct a concurrent review within 24 hours. Payment authorization for services under this procedure will be subject to the same intensity of review on the second day as if the client were being evaluated for a new admission.

8. ADMISSION CRITERIA TO EDGEMOOR HOSPITAL

Edgemoor Hospital is a County-operated Distinct Part Skilled Nursing Facility for persons 18 years of age and older who are eligible for Skilled Nursing Care based on Title 22 and Omnibus Budget Reconciliation Act (OBRA), 1987 regulations.

A. Potential residents must meet the following criteria:

- Consideration for admission will be made only after the referring acute care hospital has completed a "good faith effort" at an alternative, appropriate placement in the community. Referral packets will be accepted, and admission assessment made only after this effort has been completed.
- Referrals shall be evaluated on effectiveness of alternative placement effort, appropriateness for care in other community facilities and need for the intensity of care provided at Edgemoor Hospital.
- Bed space appropriate to the potential resident's needs must be available.
- Resident care and treatment shall be determined only by medical and nursing needs, not by source of payment.
- The potential resident or his/her legal representative must consent for Edgemoor Hospital medical staff to provide medical management and coordination of care.

B. Edgemoor Hospital generally deems "Not Appropriate" for admission because of the following:

- Persons able to receive necessary care at other facilities.
- Persons requiring acute care medical services, intensive nursing care, transfusions, and acute psychiatric care.
- Persons with a primary diagnosis of developmental disabilities or mental illness without significant skilled medical needs.
- Pregnant women.
- Persons who do not meet Medicare/Medi-Cal criteria for Skilled Nursing level of care, although

they are deemed "not easily placed" by the referring facility.

- Persons with a primary diagnosis of substance abuse or persons actively receiving treatment for substance abuse.
- Persons requiring care for violence, severe agitation, suicidal or homicidal behavior.
- Persons requiring services Edgemoor Hospital is unable to provide.

Note: Possible admissions which are rejected by the Admissions Committee can be re-submitted at any time for re-consideration.

9. MEDICATION ISSUES

The standard of care in the community is to discharge all clients with either a prescription or medications in hand. The exception would be a client who is discharging to a Short Term Acute Residential Treatment (START) program, which will facilitate getting psychiatric medications for Medi-Cal recipients. Indigent clients going to START programs can have medications filled through the County Pharmacy per agreement with SDCPH. Hospital physicians have the right to hold certain medications if client has recently attempted to overdose (OD) on prescribed medication or abuse medication.

Note: Issues related to medications for clients who are being discharged are being discussed at the Hospital Partner's meeting and at the Utilization Management Coordination meeting and will be included in the

Inpatient Operations Handbook once decisions regarding requirements and recommendations have been made.

10. CLAIMS AND BILLING

A. A Treatment Authorization Request (TAR) Manual is distributed by the State Department of Health Care Services (DHCS) formally Department of Mental Health (DMH). The most recent version is dated February 2005. This manual is most helpful in delineating instructions regarding completing TARs. Please contact Optum, San Diego County Mental Health or State DHCS for a copy of this handbook if you do not have the most recent version.

B. Submitting Treatment Authorization Requests (TARs)
The provider shall submit an original Treatment Authorization Request* (TAR) form to Optum. Optum reviews the TAR and forwards it to Conduent. Conduent will deny TARs sent directly to Conduent by a hospital. All TARs for San Diego County Medi-Cal residents must be approved by Optum prior to submission to Conduent for payment. Incomplete TARs or TARs completed with erroneous or conflicting information will not be processed and will be returned to the hospital of origin to complete/resubmit.

*Please note that TARS require an original physician signature. TARs that are signed by a nurse for the physician or have a stamped signature will be denied by Conduent. While Conduent has historically accepted these TARs, their process has changed, and the new standard is consistent with the current requirements of the TARs manual distributed by the State Department of Health Care Services.

All TARs must include the facility's National Provider Identification (NPI) Number. Conduent will not accept TARs without the facility's NPI Number.

C. Retrospective (RETRO) TARs- The hospital shall be required to send copies of the entire client chart and documentation as to why a TAR is being sent retroactively. RETRO TARS are only accepted for the following reasons:

- Retroactive Medi-Cal eligibility determinations;
- Inaccuracies in the Medi-Cal Eligibility Data System;
- Authorization of services for beneficiaries with other health care coverage pending evidence of billing, including dual-eligible beneficiaries; and/or,
- Beneficiary's failure to identify payer (e.g., for inpatient psychiatric hospital services).

All Retroactive TARS must be submitted within four (4) months from the date of the client's retroactive eligibility. TARS which are not submitted timely will be administratively denied.

In cases where the review is retrospective, the MHP's authorization decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with state requirements.

In addition to submitting the original TAR to Optum, the hospital must also submit a claim form directly to Conduent for payment of psychiatric inpatient services. Claims for Medi-Cal only clients are to be sent electronically. Medi-Medi claims are paper claims.

D. Processing TARS

Within fourteen (14) calendar days of receipt of the completed TAR from the provider, Optum Utilization Management staff reconciles the information on the TAR with clinical information obtained during admission and concurrent review and submits the completed and approved TAR to Conduent for payment processing via certified mail. A copy is forwarded to the provider. The provider may appeal non-authorization by following the appeals procedure described in the Clinical Appeals section of this handbook.

E. TAR Timelines

The following timelines are Title 9 requirements for submission of TARs.

Provider must submit TAR to Optum:

- Within fourteen (14) calendar days of client discharge.

Provider must submit a separate TAR to Optum:

- When ninety-nine (99) calendar days of continuous service are provided to a client and if the hospital stay will exceed that period of time.

Note: TARs submitted for review after the timelines specified above must include the medical record along with an explanation of why the TAR is being submitted late. TARs submitted late (Retro TARs) without a reasonable explanation may be denied administratively**.**

F. Eligibility

Providers must use the state operated Point of Service (POS) verification system to check a client's current Medi-Cal eligibility to meet the State standards.

At fee-for-service-hospitals, the client's Medi-Cal number is either verified by swiping their card through a POS reader or by checking the POS web site. A POS machine strip with the verification is printed out and must be attached to the TAR.

G. Medi-Cal as Secondary Insurance

When the primary insurance is Medicare, and it is apparent that Medicare coverage will expire within *5* days, then concurrent review and TARs submission will be conducted in the same manner as if Medi- Cal was primary." Please note that although reviews will occur within 5 days of Medicare expiration, payment authorization must be based on information presented at the time Medicare coverage expires.

Should the hospital discover after discharge that a client had Medi-Cal coverage as secondary coverage, the hospital is to submit:

- Completed TAR; and
- Verification of Medi-Cal for the dates of service;
- Complete medical record; and
- Written explanation of why the TAR is being submitted late.

Forward this documentation to:

Optum
Utilization Management
PO Box 601370
San Diego, CA 92160-1370

Optum will review the documentation for medical necessity, complete the TAR and submit it to Conduent for processing. The Optum Medical Director will notify the hospital in writing within 14 days of receipt of the completed record if any days of the admission are not authorized for payment.

11. DENIALS AND NOTICE OF ADVERSE BENEFIT DETERMINATION

A. Clinical Denials

Clinical denials are based on Title 9 Medical Necessity Criteria and the medical records submitted during the Utilization Management process. It is therefore in the provider's best interest to ensure that documentation is complete and accurate so that Optum staff may make a timely and appropriate authorization decision. All clinical denials are reviewed by a psychiatrist

B. Administrative Denials

TARs that are incomplete will be returned with a request for correction or a new TAR may be requested that provides all necessary information to allow Optum to process the TAR.

TARs which show days not authorized by Optum Utilization Management through initial and concurrent reviews will be denied in part or entirely, unless additional clinical information submitted with the TARs supports the medical necessity for the days requested.

C. Notice of Adverse Benefit Determination (NOABD)

When Optum faxes an NOABD to the client in the hospital, it is the responsibility of the hospital staff assigned to the client to present the NOABD to the client and explain his/her rights and options.

12. CLINICAL APPEALS

There are times when providers disagree with an authorization determination rendered by Optum. Providers are encouraged to communicate concerns regarding authorization decisions to Optum. Optum is committed to responding in an objective and timely manner. Optum will attempt to resolve the issue informally through direct discussion with a provider; however, if the problem is not resolved to the satisfaction of the provider, a formal appeal process is available.

A. Provider Appeals Process

The provider appeal process is governed by California Code of Regulations, Title 9, Chapter 11, Section 1850.315 Provider Appeal Process and 1850.320 Provider Appeals to the Department. Please contact the Optum Provider Line at 1-800-798-2254, option 3, if you have any questions regarding the process.

B. Expedited Review

The MHP encourages informal resolution of disagreements regarding treatment issues through direct contact with Optum. An Expedited Review of a denial/non-authorization may be requested by the attending physician at the FFS hospital. To request an Expedited Review, the beneficiary must be currently admitted to the inpatient psychiatric facility. If the beneficiary has discharged from the facility, the Expedited Review request is invalid, and the facility may utilize the formal appeal process instead.
The attending or covering physician must submit to Optum the Expedited Review request and supporting documentation from the medical record within two (2) business days of the date on the notification of denial/non-authorization. Expedited Review requests received by Optum beyond two (2) business days are invalid and the facility may utilize the formal appeal process.

Only one Expedited Review request can be submitted per denied authorization request. The facility may utilize the formal appeal process in the event that a second denial is issued. Once Optum Medical Director or Associate Medical Director has reviewed the request and supporting documentation for Title 9 medical necessity criteria, a determination to uphold or overturn the denied authorization request is made. The UM clinician will notify the facility of the determination within two (2) business days of date the complete expedited review request was received by Optum. Should the determination overturn the denied authorization request, UM staff will enter the authorization and continue with concurrent review. If the denied authorization request is upheld, the facility may utilize the formal appeals process.

C. Level I Appeal

A provider may appeal a denied or modified request for payment authorization. The written appeal is submitted to Optum within ninety (90) calendar days of the date of receipt of the non-approval of payment. The following must be submitted to request a Level I appeal:

A written request for a review of the denied request for payment authorization, including a summary of the reasons why the services should have been authorized. Clinical records including all relevant documents that support the medical necessity of services provided. Documentation supporting allegations of timeliness, if at issue, including fax records, phone records or memos.

A copy of the denied treatment authorization request (TAR). Provider's name, address, and telephone number. Signature of the authorized provider representative.

Send the request to the following address:

Optum
Attn: Quality Improvement Department
P.O. Box 601370
San Diego, CA 92160-1370

A psychiatrist not involved in the initial denial or modification of the request for payment authorization reviews the information. The provider receives a written decision within sixty (60) days of Optum receiving the request.

If the denied request for payment authorization is overturned, the provider submits a revised treatment authorization request (TAR) within thirty (30) calendar days from the date on the written decision. Please include a copy of the appeal decision letter with the new TAR.

If the denied request for payment authorization is upheld, the provider is notified of any right to submit an appeal to the California Department of Health Care Services (Level II appeal).

D. Level II Appeal

When a Level I appeal of a denied or modified request for authorization of payment is upheld, the provider may submit an appeal to the California Department of Health Care Services (DHCS). The provider submits an appeal in writing, along with supporting documentation, within thirty (30) calendar days from the date of the written decision of the Level I appeal. Supporting documentation may include but is not limited to:

- Any clinical documentation supporting allegations of timeliness, is at issue, including fax records, phone records or memos.
- Clinical records supporting the existence of medical necessity, if at issue.
- A summary of reasons why the request for payment authorization should have been approved.
- A contact name, address, and phone number.

Send the appeal and supporting documentation to the following address:

Department of Health Care Services Mental Health Services Division
1500 Capitol Avenue, Suite 72.442, MS 2703
Sacramento, CA 95814
916-319-0985

The DHCS notifies Optum and the provider of receipt of a request for appeal within seven (7) calendar days. The DHCS asks Optum for specific documentation supporting the decision to deny payment. Optum submits the required documentation to the DHCS within twenty-one (21) calendar days of notification of the appeal or the DHCS finds the appeal in favor of the provider.

The DHCS has sixty (60) days from the receipt of the documentation from Optum to notify the provider and Optum in writing of the decision and its basis. At the election of the provider, if the DHCS does not respond within sixty (60) calendar days from the postmark date of documentation from Optum, the appeal is deemed upheld.

If the DHCS upholds the original decision to deny reimbursement, a review fee is assessed to the provider (DM11 Letter #03-07). If the DHCS overturns a provider appeal, the provider is notified in writing with

instructions to submit a new TAR to Optum.

13. ADMINISTRATIVE DENIAL APPEAL (FOR RETRO TARS ONLY)

Should the facility disagree with an administrative denial of a retroactive authorization request, an appeal may be requested. The appeal request must be received by Optum within ninety (90) days of the date on the administrative denial notification.

To request an administrative denial appeal, submit the following to Optum:

- A written request for a review of the administrative denial of the retroactive authorization request.
- A copy of the complete chart including all relevant documents that support submission criteria for retroactive authorization requests.
- A copy of the denied treatment authorization request (TAR).

Send the appeal request to the following address:
Optum
Attn: Quality Improvement Department
PO Box 601340
San Diego, CA 92160-1340

The County of San Diego, HHSA, BHS Quality Management will review the information and render the final determination. The facility will receive a written decision within thirty (30) business days of receipt of the request. Should the administrative denial be overturned, Optum Utilization Management will review the chart for California Code of Regulations Title 9 medical necessity criteria.

14. USING THE COUNTY OF SAN DIEGO MENTAL HEALTH SERVICE MANAGEMENT INFORMATION SYSTEM (MH MIS)

To meet State and Federal reporting requirements and to facilitate coordination of client care, the County of San Diego uses the MH MIS client data recording system. MH MIS is used to register clients into the mental health system, to record service activities, and to update care coordination information. During the initial authorization process, Optum enters a limited set of information from inpatient providers about adult Medi-Cal hospital admissions into the MH MIS system within one business day of the admission. Hospital staff should check MH MIS, if possible, for information about clients' Outpatient Mental Health Services, and assigned Care Coordinator or Case Manager.

Training on the MH MIS system (CCBH) is available to hospital staff upon request. Please contact:

QIMatters.hhsa@sdcounty.ca.gov

15. COORDINATION OF CARE

In accordance with State and Federal regulations, and within the guidelines of San Diego County Behavioral Health Services policies regarding confidentiality and release of information, hospital providers are expected to coordinate care with other healthcare and mental health providers who are also serving their clients. As clarified in Department of Mental Health Information Notice #04-07, information may be released without written permission when it will be used for diagnosis and treatment purposes, on an as needed basis. This allowance is based on Civil Code Section 56.10 which states that: "A provider of healthcare or a healthcare

services plan may disclose medical information to providers of healthcare, healthcare services plans, or other healthcare professional or facilities for purposes of diagnosis or treatment of the patient."

A. Outpatient Care Coordination

Care Coordinator or Case Manager: Clients who are already involved or have recently been involved in the Specialty Mental Health Care System, in many cases, have a Care Coordinator. A Care Coordinator, such as a clinic therapist or an intensive case manager, is the person assigned to each individual client who is responsible for ensuring that the client receives all needed services. The Care Coordinator is responsible for integrating the client's treatment and care and assists the client in obtaining needed services both within and outside the organization. In order to coordinate care at the time of an inpatient admission, hospital staff should make an effort to obtain information regarding the client's assigned Care Coordinator. One method to accomplish this goal is to check the County's Mental Health Management Information System client data recording system. The goal is for the Care Coordinator to be contacted within 48 hours of admission to the inpatient setting, or as soon as possible.

The type of information the hospital staff may share with the Care Coordinator should include, but not be limited to:

- Date of admission;
- Circumstances of admission;
- Medication, and any changes in medication;
- Notification of any certification hearings or plans regarding Conservatorship;
- Discharge planning and/or discharge plan;
- Date planned discharge;
- Notification of client leaving hospital Against Medical Advice (AMA).

In order to ensure that the client will receive continuity of care between providers of all services, the Care Coordinator will interact with hospital staff by participating in the following ways:

- Communicating with hospital staff about client's treatment;
- Reviewing the discharge plan with hospital staff and assisting with the discharge plan when appropriate;
- Assisting to ensure that the client is seen by a mental health care professional within 72 hours of discharge from the hospital.

B. Transitional Services

1. Transition Team: Adult/Older Adult

The Transition Team (Telephone Number: 619-683-3100), operated by Telecare Corporation, under contract with the Mental Health Plan, provides a clinical review of all adult/older adult Medi-Cal recipients admitted to Medi-Cal contract hospitals. This review occurs within three (3) working days of notification that an individual was admitted to an acute care psychiatric unit. For Medi-Cal clients with a Conservator, Care Coordinator or Case Manager, the Transition Team is not needed. For Medi-Cal clients without such support, the Transition Team will make contact directly with the client and offer short-term case management services. Participation is voluntary.

The Transition Team will maintain a clinical case management record for each client who is enrolled. The goals of Transition Team services are to aid in the re-stabilization of clients in the community (following an acute psychiatric hospitalization) and to facilitate a smooth, rapid transition to requested community resources. Together, the client and Transition Team Case Manager develop an Individual Service Plan, and the Case Manager monitors the client's progress in the hospital, supports hospital

discharge planning, and promotes linkage of the client with aftercare resources. The team will provide services and support, as necessary, to achieve the client's treatment plan goals and objectives. Transition Team services are short- term and dependent upon the requests and needs of the individual client. Upon completion of Transition Team services, clients may choose to link with Care Coordinators, Case Managers or other community providers, or choose not to participate in additional mental health services.

2. Transitional Services Program: Children/Adolescents

The Crisis Action and Connection (CAC) program (Telephone Number: 619-591-5740 or 619-591-5744), operated by New Alternatives, Inc, under contract with the Mental Health Plan, provides qualifying children and adolescents a smooth and rapid transition/diversion from an inpatient psychiatric hospital and/or Emergency Screening Unit (ESU) to the community. The program focuses on diverting children and adolescents from inpatient psychiatric care and/or aids in the stabilization process following inpatient psychiatric care. The CAC program accomplishes these goals by promoting the utilization of appropriate community resources and continuity of care within the behavioral health system as well as providing post-hospitalization linkage for families to community resources to help prevent the need for re-hospitalization. These services are short-term and transitional in nature until the child/adolescent is connected to behavioral health services within their community. All clients are assessed within five (5) working days from the date of referral.

C. Discharge Planning

In order to facilitate continued treatment and prevent re-admission, discharge plans shall be completed for all clients being discharged from an acute level of care. Planning for discharge shall begin on the day of admission. Discharge planning shall include:

- Attempting contact with the client's Care Coordinator within 48 hours of admission;
- Coordinating with the Short-Term Transition Team if no Care Coordinator is identified
- Contacting the Regional Center for appropriate clients;
- Planning for appropriate living arrangements for the client upon discharge;
- Planning for discharge to the appropriate level of care, including organizational, residential, or outpatient providers;
- Consideration of prior failures and successes of the client in an effort to design an effective discharge plan;
- Contacting an outpatient provider and requesting an appointment for providers and programs that schedule appointments (such as children's programs) to be scheduled for the client as soon as possible, or a referral to a walk-in program, with the targeted goal that the client is seen within three (3) business days of the client's discharge from the facility;
- Requesting a Release of Information (ROI) from the client to facilitate coordination of care between the acute setting and the outpatient provider (an ROI is not required for coordination, diagnosis or treatment purposes; however, it is a good practice and helps the client be more actively involved in their care);
- Sending fax to the referral program with the information about the client that has been referred in order to ensure that the program is aware that the client is coming;
- Identifying plan for client to obtain medications after discharge.

Optum Utilization Management staff review the discharge planning progress during the clinical record review process.

SB 1152 Hospital Patient Discharge Process: Homeless Patients Summary

Each hospital shall have a written discharge policy and process which requires that appropriate arrangements for posthospital care are made prior to discharge for those that are likely to suffer adverse

health consequences upon discharge if there is no adequate discharge planning.

A) The patient shall be provided the opportunity to identify one family caregiver who may assist in posthospital care.
B) A transfer summary shall accompany the patient upon transfer to a skilled nursing or intermediate care facility and given to the patient and their legal representative prior to the transfer.
C) A policy will be established to ensure each patient receives information regarding medication dispensed.
D) A hospital shall provide every patient anticipated to be in need of long-term care at the time of discharge with contact information for at least one public or non-profit agency for community-based long-term care options in the patient's county of residence and appropriate to the client's needs.

Each hospital shall include within its discharge policy a written homeless patient discharge planning policy and process, including information about the patient's housing status and individual discharge plan.

A) Unless transferred to another LHF, the policy is to identify a post discharge destination with priority given to identifying a sheltered destination with supportive services.
B) A social service agency, non-profit social service provider or governmental service provider that has agreed to accept the homeless patient.

The policy shall require that information regarding discharge or transfer be provided to the homeless patient in a culturally competent manner and in a language that is understood by the homeless patient.

This hospital shall document all of the following prior to discharging a homeless patient: Clinical stability for discharge, offering of a meal, appropriate clothing, follow up care, prescription, screening for infectious disease, vaccinations, medical screening (referral to health plan, primary care or another provider if necessary); screened for and provided assistance to enroll in, any affordable health insurance coverage for which he or she is eligible; transportation after discharge within 30 minutes travel time from the hospital.

A hospital shall develop a written plan for coordinating services and referrals for homeless patients with the county behavioral health agency, health care and social services agencies in the region, health care providers, and non-profit social services providers to assist with ensuing appropriate homeless patient discharge. The plan shall be updated annually and include:

A) A list of homeless shelters
B) Hospital procedures for homeless patient discharge referrals
C) The contact information for the homeless shelter's intake coordinator
D) Training protocols for discharge planning staff
E) Each hospital shall maintain a log of homeless patients discharged and the destinations to which they were released.

Refer to California Hospital Association Discharge Planning Book for further information.

D. Coordination with Other Levels of Care

Early & Periodic Screening, Diagnosis & Treatment (EPSDT) Brochure

In accordance to CCR, Title 9, Chapter 1, Section 1810.310 (a)(1), providers are to provide the DHCS issued **Medi-Cal Services for Children and Young Adults: Early & Periodic Screening, Diagnosis & Treatment (EPSDT) brochures**, which includes information about accessing Therapeutic Behavioral Services (TBS) to Medi-Cal (MC) beneficiaries under 21 years of age and their

representative, **at the time of admission** to any of the following facilities: Specialized Treatment Program (STP), Mental Health Rehabilitation Center (MHRC) that has been designated as an Institution of Mental Diseases (IMD), Rate Classification Level (RCL) 13-14 Foster Care Group Home or RCL 12 Foster Care Group Home. Providers shall document in the client chart that brochure was provided to the client/family/caregiver.

See the links to the EPSDT brochures for English and Spanish.

http://www.dhcs.ca.gov/services/MH/Documents/EPSDT_TBSEng.pdf
http://www.dhcs.ca.gov/services/MH/Documents/EPSDT_TBSSpa.pdf

Crisis Residential Services

Upon inpatient admission, or as a step-down plan, clients can be referred to Crisis Residential Services.

Clients who do not meet, or no longer meet, the Title 9 criteria for inpatient services may be referred to a crisis residential facility if the following criteria are met:

- Be in psychiatric crisis too severe to be handled on an outpatient basis and have an Axis I diagnosis other than a substance-induced disorder. This includes individuals experiencing an acute life crisis, an acute phase of a chronic psychiatric disorder, or an acute psychiatric episode;
- Be capable of maintaining safety;
- Be voluntarily requesting services and willing to go to the crisis residential facility;
- Not be actively violent or in need of restraints (but may have a history of violence if currently able to control impulses);
- Be free from non-psychiatric medical conditions, which would require more than outpatient medical care;
- Not have a substance abuse or substance dependence diagnosis, in absence of a mental health diagnosis;
- Be ambulatory as defined by Community Care Licensing (unless occupying room approved by Fire Department and Community Care licensing for non-ambulatory). Some facilities have waivers to admit non-ambulatory clients. "Ambulatory" is defined as the ability to exit the facility quickly without assistance from any person or device such as a cane, walker, or crutches;
- Clients over 59 who are compatible with the current population will be accepted only upon approval by Community Care Licensing. All crisis residential facilities are able to routinely get approval to admit a limited number of individuals over age 59.

E. Referrals to Long-Term Care Services and Skilled Nursing Facilities

The Mental Health Plan (MHP) contracts with Institutions for Mental Disease (IMDs), Skilled Nursing Facilities (SNF), SNF Patch, Neurobehavioral Health Patch, and Specialized Residential Treatment to meet the needs of San Diego residents who require the most intensive, secured, 24-hour setting. The MHP also manages the care of San Diego residents placed in out-of-county IMD and State Hospitals.

- **General Admission Criteria**

  - The client is diagnosed with a non-substance abuse related, non-developmental related, non-medical related Title 9 included diagnoses, according to the current DSM typology. Clients may also have a concurrent substance or developmental diagnosis; however, these diagnoses alone are not sufficient to meet criteria;

- The client is gravely disabled based on the Axis I diagnosis and is on conservatorship;
- Medical issues are stabilized;
- The client has a current history of being unable to adequately care for him or herself outside of a locked setting;
- The client is in need of long-term locked treatment or a skilled nursing facility in order to facilitate rehabilitation to a lesser level of care or to prevent regression to a more acute state;
- The client is a resident of San Diego County, with San Diego Medi-Cal or has other coverage available to fund ancillary services;
- The client is 18 years of age or older;
- The client is on a stable, clinically appropriate medication regiment;
- The client does not have a history of multiple assaultive episodes or is not currently suicidal;
- If referral is for a SNF Patch, client must meet Managed Care Plan SNF Guideline Criteria.
- For a more comprehensive list of criteria for LTC placement based on Level of Care, refer to the San Diego Funded LTC Criteria see Appendix G.

- **Referral Process**

  - Completed Long Term Care Referral Packets (Appendix H) can be faxed to the Long-Term Care Coordinator at 888-687-2515. Questions can be directed to the Long-Term Care Provider Line at (800) 798-2254 #3. The Long-Term Care Coordinators will review requests with the Optum Medical Director who will determine the appropriateness of the referral.

F. Interface with Medi-Cal Managed Care Health Plans

Note: The information presented in the following section is in accordance with the Memorandum of Agreement (MOA) between County of San Diego Health and Human Services Agency Local Mental Health Plan (MPH) and the Medi-Cal Managed Care Plans.

- **HMO Medi-Cal Beneficiaries**

  Over 50% of Medi-Cal beneficiaries are enrolled in one of the Health Maintenance Organizations (HMOs) that are part of Healthy San Diego. To help facilitate communication and coordinate physical and mental health services, Healthy San Diego has prepared a Physical and Mental Health Coordination Form and Guidelines for its use. Each HMO has contracts with specific pharmacies and laboratories. Providers need to be aware of which pharmacy or laboratory is associated with the HMO serving the client for whom they are prescribing medication or lab tests in order to refer the client to the appropriate pharmacy or lab. Providers prescribing lab tests may refer the client back to his or her Primary Care Physician (PCP) for these services. The client's HMO enrollment card also may have a phone number that providers and clients can check in order to identify the contracted pharmacy or lab.

- **Physical Health Services While in A Psychiatric Hospital**

  The client's Healthy San Diego HMO will cover and pay for the initial health history and physical assessment required upon admission to a psychiatric inpatient hospital. The client's HMO is also responsible for any additional or on-going medically necessary physical health consultations and treatments. The MHP contracted psychiatrist is responsible for obtaining the psychiatric history upon admission, and for ordering routine laboratory services. If the psychiatrist identifies a physical health problem, he or she contacts the client's HMO to request an evaluation of the problem. If the psychiatrist determines further laboratory or other ancillary services are needed, the contracted facility must obtain the necessary authorizations from the HMO. The client's HMO contracted providers are to provide these services, unless the MPH contracted facility obtains prior

authorization from the HMO to use a provider not contracted with the client's HMO.

- **Transfers from Psychiatric Hospital to Medical Hospital**

  Psychiatric hospitals may transfer a client to a medical hospital to address a client's medical problems. The psychiatric hospital must consult with appropriate HMO staff to arrange transfer from a psychiatric hospital to an HMO contracted hospital if it is determined that the client requires physical health-based treatment. The Optum Medical Director and the HMO Medical Director shall resolve any disputes regarding transfers.

- **Non-Emergency Medical Transportation**

  Healthy San Diego HMOs cover medically necessary non-emergency medical transportation services for Plan members. HMO members who call the Access and Crisis Line for medical transportation are referred to the Member Services Department of their HMO to arrange for such services.

G. Beneficiaries Not Enrolled in Medi-Cal Managed Care Health Plans

For those clients who are not members of a Healthy San Diego HMO, physical health services provided in a psychiatric hospital are reimbursed by Medi-Cal.

H. Authorization for Transfer between Hospitals

Medi-Cal clients may be transferred from one hospital to another or from one floor to another within the same hospital, according to the following guidelines:

- Medical necessity criteria is clearly established for the client
- Referring hospital may contact Optum to request an authorization to reduce the potential for transferring a client who no longer meets medical necessity
- The referring hospital should arrange for transportation to the receiving hospital.

The receiving hospital/floor shall meet the following conditions:

- Have a bed available to receive the client;
- Have an attending physician available for the client;
- Be willing to accept the clinical information of the referring hospital/floor or be willing to conduct a new assessment of the client within 24 hours of admission.

These authorization conditions apply equally for:

a) Psychiatric to psychiatric hospital transfer;
b) Medical to psychiatric hospital transfer;
c) Medical floor to psychiatric floor transfer within the same hospital.

Optum clinical staff will provide authorization to the receiving hospital/floor if the above conditions are met. Please note: When there is a transfer between hospitals, once the client has been admitted to the second hospital that that hospital will be responsible for obtaining any further the authorizations.

I. Authorization Process for the Emergency Psychiatric Unit (EPU) of the San Diego County

Psychiatric Hospital and for Receiving Hospitals:

When a client has been assessed in the EPU as requiring inpatient hospitalization and is insured, the EPU staff will seek an available bed for that client in the Lanterman-Petris-Short (LPS) unit of a participating hospital. If the client is a Medi-Cal recipient, the receiving hospital follows the same admission procedure they would for any requests for reimbursement for acute care as well as for subsequent days. If the client is a Medicare A&B recipient, the EPU will confirm this status and inform the receiving hospital. Private insurance carriers are contacted by the receiving hospital for authorization.

J. For Sending Hospitals:

If a client is assessed in a hospital Emergency Room as needing inpatient care and is uninsured, the facility faxes a completed San Diego County Psychiatric Hospital (SDCPH) Request for Transfer Form to SDCPH, along with other standard referral material. SDCPH acknowledges the receipt of the request within one hour, and gives a preliminary standing based on established criteria. The SDCPH staff manages and prioritizes the referrals, accepting clients who are medically stable and otherwise appropriate, as bed space allows.

16. BENEFICIARY RIGHTS

San Diego County Behavioral Health Services is committed to protecting client's rights in accordance with State and Federal Regulations and County policy. Violations of clients' rights will be responded to appropriately.

A. Confidentiality

Maintaining the confidentiality of client and family 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.

B. Client Handbooks

Providers are required to give each client a Client Handbook at the client's admission, or upon request. The handbook is titled: County of San Diego – Guide to Medi-Cal Mental Health Services. The beneficiary handbooks contain 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 (Appendix I) and a description of the beneficiary's right to request a State fair hearing. Guides are written by the State with updates by the MHP. They are available for download and printing at www.optumsandiego.com in the Manuals tab.

All clients also must receive a copy of the State Handbook, Rights for Individuals in Mental Health Facilities. This 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 Jewish Family Service for the Patient Advocacy Program (1-800-479-2233) to assist clients with grievances and appeals. The Patient Advocacy Program distributes an informing brochure for clients called "Seclusion & Restraint: Answers to Your Questions."

C. Translation Service Availability

According to Title 9 and Title IV, Civil Rights Act of 1964, interpreter services shall be available to beneficiaries 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.

D. Client Grievances and Appeals

Clients may contact Jewish Family Service, 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 clients 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 and the State DHCS designated threshold languages which are Spanish, Vietnamese, Arabic, Tagalog, and Farsi for San Diego County) in a visible area to ensure clients are advised of their rights. Title 9 requires brochures are available to both clients and provider staff without the need of a verbal or written request by the client. Copies of the Grievance and Appeal posters and brochures may be obtained completing the Beneficiary Materials Order form available at www.optumsandiego.com and sending the request form to QIMatters.hhsa@sdcounty.ca.gov or fax (619) 236-1953.

Clients may file an appeal of an action taken by the Mental Health Plan (MHP) such as any of the following:

a. A denial or modification of services,
b. A reduction, suspension or termination of a previously authorized services,
c. A denial, in whole or part, of payment for a service,
d. Failure to provide services in a timely manner (within 1 hour for emergency care).

If a client wishes to file an appeal, the provider should inform them that they should contact the Patient Advocacy Program at 1-800-479-2233.

If the standard resolution process for an appeal could, in the opinion of the client, the MHP, CCHEA or Patient Advocacy Program jeopardize the client's life, health or ability to attain, maintain, or regain maximum function, the client has the right to file an Expedited Appeal. Expedited Appeals may be filed for any of the reason listed above but must resolved within three (3) working days (Appendix I).

Inpatient providers are required by Title 9 to maintain a log in which all client or family concerns or grievances are entered. Concerns may be expressed verbally or in writing. The log must include the following elements:

a. Complainant's name
b. Date the grievance was received
c. Name of person logging the grievance
d. Nature of the grievance
e. Nature of the grievance resolution
f. Date of resolution

The MHP may request a copy of a provider's Grievance Log at any time.

E. Client Right to Request a State Fair Hearing

Clients have the right to request a **State** Fair Hearing any time before, no later than 120 calendar days from the date of the MHP's written appeal resolution, after the completion of the beneficiary problem resolution process, whether or not the client uses the problem resolution process and whether or not the client has received a Notice of Adverse Benefit Determination. Providers are required to inform their clients or the clients' conservators/legal guardians of these rights.

F. Client Right to Have an Advance Health Care Directive

All new clients must be provided with the information regarding the right to have an Advance Health Care Directive at their first face-to-face contact for services. This procedure applies to emancipated minors and clients 18 years and older. Generally, Advance Directives addresses 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 himself/herself. The MHP provides an informational brochure on Advance Directives, available in the threshold languages. They are available for download and printing at www.optumsandiego.com in the Beneficiary tab.

G. Title 42 CFR Section 438.100 – Addressing Beneficiary's Rights

(1) General rule. The State must ensure that—

(i.) Each MCO and PIHP has written policies regarding the enrollee rights specified in this section; and

(ii.) Each MCO, PIHP, PAHP, and PCCM complies with any applicable Federal and State laws that pertain to enrollee rights and ensures that its staff and affiliated providers take those rights into account when furnishing services to enrollees.

(2) Specific rights—

(i.) Basic requirement. The State must ensure that each managed care enrollee is guaranteed the rights as specified in paragraphs (b)(2) and (b)(3) of section 438.100.

(ii.) An enrollee of an MCO, PIHP, PAHP, or PCCM has the following rights: The right to—

(a) Receive information in accordance with 42 CFR §438.10.

(b) Be treated with respect and with due consideration for his or her dignity and privacy.

(c) Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand. (The information requirements for services that are not covered under the contract because of moral or religious objections are set forth in 42 CFR §438.10(f)(6)(xii).

(d) Participate in decisions regarding his or her health care, including the right to refuse treatment.

(e) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.

(f) If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and §164.526.

(g) An enrollee of an MCO, PIHP, or PAHP (consistent with the scope of the PAHP's

contracted services) has the right to be furnished health care services in accordance with 42 CFR§438.206 through §438.210.

(3) Free exercise of rights. The State must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO, PIHP, PAHP, or PCCM and its providers or the State agency treat the enrollee.

(4) Compliance with other Federal and State laws. The State must ensure that each MCO, PIHP, PAHP, and PCCM complies with any other applicable Federal and State laws (such as: title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; and Titles II and III of the Americans with Disabilities Act; and other laws regarding privacy and confidentiality).

(5) Hospital facilities must inform individuals who are subject to a lifetime ban on gun ownership due to involuntary admission (5151) into a locked designated facility due to DTS or DTO and who have a previous admission in the past year, but the facility can no longer submit the Patient Notification of Firearm Prohibition and Right to Hearing form BOF 4009C on behalf of the client.

17. QUALITY IMPROVEMENT

Site reviews will be conducted tri-annually. Requirements are based on State standards for Medi-Cal certification. On-site reviews shall occur during normal business hours with at least 72-hours prior notice; except unannounced on-site reviews and requests for information may be made in those exceptional situations where arrangement of an appointment beforehand is clearly not possible or clearly inappropriate due to the nature of the intended visit.

Providers are required to adhere to all applicable Federal, State, and County regulations, policies and statutes, including Title 9 and Department of Health Care Services (DHCS, formerly DMH) Letters and Notices. Relevant Letters published in 2004 included but are not limited to:

- DMH Letter 04-04, which requires hospitals to provide EPSDT and TBS notices to full scope individuals 18-21 admitted with an emergency psychiatric condition.
- DMH Information Notice 04-05**,** which discusses the Emily Q. v. Bonta Appeal settlement and criteria special service eligibility for those ages 21-25.

Providers are required to conduct client satisfaction surveys.

All County and contracted providers are required to report serious incidents involving clients in active treatment or whose discharge from services has been 30 days or less. Required reports shall be sent to the Behavioral Health Services (BHS) Quality Management (QM) Unit that will review, investigate as necessary, and monitor trends. BHS-QM designated staff will communicate with program Contracting Officer's Representatives (CORs) and Behavioral Health Services (BHS) management staff as needed on all reported serious incidents. The provider shall also be responsible for reporting serious incidents to the appropriate authorities (Appendix J).

All mental health providers are required to adhere to cultural competence standards. The QI staff will look for elements of cultural competence in program orientations, staffing, charting and/or trainings during site reviews.

Reports Required: All Lanterman-Petris-Short (LPS) facilities are required by the State DHCS to submit the following quarterly reports to County Mental Health Services Quality Improvement Unit, using the State

forms Appendices:

- 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 (Appendix K).
- Quarterly Report on Involuntary Detentions (MH 3825) —not required for non Lanterman-Petris-Short LPS facilities (Appendix L).
- Convulsive Treatment Administered—to include Outpatient ECTs (Appendix M).

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

Please note that because of HIPAA confidentiality requirements completed forms containing client identifiers are not allowed to be electronically submitted. These reports can be mailed to P.O. Box 85524, San Diego, 92106 or faxed to the QI Unit confidential fax at 619-236-1953.

18. QUALITY OF CARE STANDARDS

Psychiatric inpatient providers shall be committed to providing dignified care and treatment to individuals who struggle with mental illness and substance abuse. Providers shall strive to restore the client to optimal functioning in the shortest amount of time and in the least restrictive and most comfortable environment possible. Providers will involve the client's natural support system and include them in the clients' treatment planning and care. Providers shall understand that it is common for people with mental illness to experience stigma and barriers to social integration and shall be committed to eliminating stigma and to promoting the fullest recovery for each individual.

Psychiatric inpatient Providers shall abide by their respective discipline's guidelines such as those noted on the following websites. Appendix N includes other helpful websites.

CA Psychiatric Association	www.calpsych.org
American Psychiatric Nurses Association- CA Chapter	www.apnaca.org
National Association of Social Workers- CA	www.naswca.org
CA Association of Marriage and Family Therapists	www.camft.org
California Psychological Association	www.cpapsych.org

Inpatient Treatment for Children and Adolescents

BHS supports the use of inpatient services for children and adolescents and recommends that inpatient facilities follow quality of care guidelines such as those published by the Association of Child and Adolescent Psychiatric Nurses, and the American Academy of Child and Adolescent Psychiatry. The following are examples of quality guidelines for facilities providing child or adolescent inpatient treatment:

- Treatment program should be under the direction of a fully trained and properly qualified child and adolescent psychiatrist.
- Decisions for admitting and treating children and adolescents in an inpatient setting must be very carefully considered. This would include the diagnosis of a psychiatric disorder as defined by the most recent version of the DSM and criteria for inpatient psychiatric hospitalization such as those described in the American Academy for Child and adolescent Psychiatry's Guidelines for Treatment, Quality Assurance, and Peer Review.
- Children and adolescents and their families shall have an opportunity to explain their perception of the behaviors and symptoms that prompted the admission
- Treatment plans must be individualized based on the assessment of the client's biological, psychological and social needs.

- The child or adolescent and their family should be encouraged to participate voluntarily in the decision for admissions, treatment and discharge planning.
- Care should be coordinated with the child or adolescent's other healthcare providers
- Prescriptions should be based on individual characteristics, such as culture, ethnicity, gender, religious beliefs, and age.

Appendix A

**PROCEDURE FOR VOLUNTARY ELECTROCONVULSIVE TREATMENT (ECT)
(INCLUDING ANY CLIENT UNDER GUARDIANSHIP OR LPS CONSERVATORSHIP 18 YEARS OF AGE OR OLDER)**

PROCEDURE FOR VOLUNTARY ELECTROCONVULSIVE TREATMENT (ECT)
(Including Any Client Under Guardianship or LPS Conservatorship 18 Years of Age or Older)

I. The client's outpatient or inpatient treating psychiatrist:

1. Determines the need for electroconvulsive treatment (ECT) based on community standard guidelines *(usually moderate to severe primary affective disorder):*
   - *Not responsive to less intensive forms of treatment, or*
   - *When the client is unable to tolerate other forms of treatment, or*
   - *When the client's psychiatric illness is so severe that relief of symptoms is medically urgent and documents this in the client's medical record;*

2. Prepares a written supplement to the standard consent form containing details pertaining to the particular client (*This supplemented form must specify a maximum number of treatments over a maximum period not to exceed 30 days.*).This signed documentation includes clinical reasons for the procedure, and a statement that all reasonable treatment modalities have been carefully considered, that the treatment is definitely indicated and is the least drastic alternative for this client at this time (Form MH:300);

3. Determines that in his/her opinion this client is capable of written informed consent: Written informed consent requires that a person knowingly and intelligently, without duress or coercion, clearly and expressly manifests consent to the treating psychiatrist and in writing on the standard consent form. A person is incapable of written informed consent if he/she cannot understand or intelligently act on the information given;

4. Requests that a Board Eligible or Board-Certified Psychiatrist (or Neurologist) reviews the treatment proposal relative to the client's ability to give written informed consent for ECT. If this consulting psychiatrist finds that the client is not able to give written informed consent, the procedure for involuntary ECT may be considered by the treating psychiatrist. If this consulting psychiatrist agrees that the client is able to give written informed consent and documents this finding on the form entitled, "Consulting Psychiatrist's Statement – Electroconvulsive Treatment for Voluntary Patients" [Form HHSA:MHS-195 (02/00)], then;

5. The client's treating psychiatrist presents the supplemented consent form to the client, explains it in detail, and presents the same information to another party at the client's request (family member, friend, or guardian may also review the consent form at the client's request and with the client's consent), and documents these explanations in the treatment record with the date and time the form and explanation were presented. The LPS Conservator, if one is currently appointed, shall be fully informed regarding ECT proposed for their Conservatee.

II. Client gives written informed consent for ECT after a minimum delay of 24 hours following the procedure described in I.5.

III. For clients under guardianship or on LPS Conservatorship (or being involuntarily detained in a hospital for psychiatric treatment), the client's Attorney or Court Appointed Public Defender must agree to the client's capacity to give written informed consent and that he/she has done so, and documents this in the client's treatment record (*Counsel may be appointed by the client, or Court must be petitioned to appoint the Public Defender as a precedent to a decision regarding ECT*). If Counsel disagrees with the client's ability to give written informed consent, procedure for involuntary ECT may be considered by the client's treating psychiatrist.

IV. The treating psychiatrist refers the client to the psychiatrist performing ECT (If ECT is not to be given by the treating psychiatrist), and treatment is scheduled. All steps and evaluations are to be fully documented in the client's treatment record. All pertinent documentation and medical evaluation results, including completed informed consent, must be provided to the facility where the ECT is to be given (*If more treatments are required than were authorized in the initial informed consent, the procedure must be reinitiated beginning with I.1*).

V. The consenting party may withdraw Informed Consent for ECT at any time prior to treatment.

VI. If ECT is to be paid from the Mental Health budget for indigent care, then prior authorization is required

from the Local Mental Health Director or his/her designee. This authorization is contingent on meeting the criteria for indigent services (UMDAP).

If ECT is to be paid for by specialty mental health Medi-Cal funds, then prior authorization is required from the Administrative Service Organization Medical Director or the Local Mental Health Director (or designee). This authorization is contingent on clinical considerations relevant to Utilization Management under Medi-Cal regulations. It is expected that all alternate client resources and entitlements will be utilized for ECT and the required medical evaluation prior to authorizing the utilization of County specialty mental health resources.

VII. Outpatient ECT may be approved under the following circumstances:

1. The client has begun ECT on an inpatient basis and requires continuing treatments, but no longer requires inpatient care, **or**

2. The client is an outpatient who requires ECT but does not meet criteria for inpatient admission, **and**

3. The client has sufficient community support for safe outpatient ECT. Support may be provided by the client's personal resources (such as, family and friends) or may be arranged by the treating psychiatrist or treatment team, such as home health services, if available

Appendix B

CONSULTANT PSYCHIATRIST'S STATEMENT – ELECTROCONVULSIVE TREATMENT FOR VOLUNTARY CLIENTS

Consultant Psychiatrist's Statement – Electroconvulsive Treatment for Voluntary Clients

I, the undersigned Psychiatrist, have reviewed the treatment record of

_____, which include the psychiatric history and
(Client)

Examination by _____, MD, and specific statements by
(Treating Psychiatrist)

_____, MD, indicating this client's competence
(Treating Psychiatrist)

to consent to electroconvulsive treatment as defined in Welfare and Institutions Code 5326.5 as follows: Written informed consent requires that a person "knowingly and intelligently, without duress or coercion, clearly and expressly manifests consent to the proposed therapy to the treating physician and in writing on the standard consent form."

Based on my personal examination of the client, and my review of the client's treatment record, I agree with the opinion and recommendation of this client's treating psychiatrist, that is client is competent to consent to electroconvulsive treatment.

Date: _____ Consultant
Psychiatrist: _____

HHSA: MHS – 195 (06/2016)

County of San Diego
Health and Human Services Agency
Behavioral Health Services

Appendix C
ELECTROCONVULSIVE TREATMENT (ECT), INFORMED CONSENT FORM

State of California Department of Health Care Services Health and Human Services Agency

ELECTROCONVULSIVE TREATMENT (ECT), INFORMED CONSENT FORM

DO NOT SIGN THIS FORM UNTIL YOU HAVE ALL THE INFORMATION YOU DESIRE CONCERNING ELECTROCONVULSIVE TREATMENT (ECT).

The nature and seriousness of my mental Condition, for which ECT is being recommended, is:

_____

RECOMMENDATION: I understand that ECT involves passage of an electrical stimulus across my brain for a few seconds, sufficient to induce a seizure. In my case the treatments will probably be given__ times per week for__weeks, not to exceed a total of _____treatments and not to exceed 30 days from the first treatment. Additional treatments cannot be given without my written consent.

Reasonable alternative treatments (such as psychotherapy and/or medication) have been considered and are not presently recommended by my doctor because

IMPROVEMENT: I understand that ECT may end or reduce depression, agitation and disturbing thoughts. In my case there may be permanent improvement, no improvement, or the improvement may last only a few months. Without this treatment my condition may improve, worsen or continue with little or no change.

SIDE EFFECTS AND RISKS: I understand there is a division of opinion as to the effectiveness of this treatment as well as uncertainty as to how this procedure works.

I also understand this treatment may have brief side effects: headaches, muscle soreness and confusion.

There may be some memory loss which could last less than an hour or there may be a permanent spotty memory loss. Memory loss and confusion may be lessened by the use of unilateral (one-sided) electrical brain stimulation rather than bilateral (two-sided) stimulation.

Anesthesia and muscle relaxants will be used during these treatments to prevent accidental injury. Oxygen will be administered to minimize the small risk of heart, lung, brain malfunction or death as a result of the anesthesia or treatment procedures.

My physician states I have the following medical condition(s) which increase the risk in my case, as follows:

I HAVE THE RIGHT TO ACCEPT OR REFUSE THIS TREATMENT. IF I CONSENT, I HAVE THE RIGHT TO REVOKE MY CONSENT FOR ANY REASON AT ANY TIME PRIOR TO OR BETWEEN TREATMENTS.

Dr._____has explained the above information to my satisfaction. At least 24 hours have elapsed since the above information was explained to me. I have carefully read this form or had it read to me and understand it and the information given to me.

I HEREBY CONSENT TO ECT _____

Signature Date and Time

_____

Witness Signature

DHCS 1800 (05/19)

Appendix D
ELECTROCONVULSIVE TREATMENT (ECT), INFORMED CONSENT FORM (SPANISH)

State of California - Health and Human Services Agency Department of Health Care Services

ELECTROCONVULSIVE TREATMENT (ECT), INFORMED CONSENT FORM

NO FIRME ESTE FORMULARIO SINO HASTA QUE TENGA TODA LA INFORMACION QUE DESEA CON RESPECTO AL TRATAMIENTO ELECTROCONVULSIVO (ECT – *ELECTROCONVULSIVE TREATMENT).*

La naturaleza y gravedad de mi estado mental para el cual se ha recomendado el ECT, es _____

_____

RECOMENDACION: Entiendo que el ECT es el proceso de pasar estimulación (corriente) eléctrica a través del cerebro por unos segundos de modo adecuado para producir una convulsión. En mi caso, es posible que los tratamientos se me darán _____veces por semana durante_____semanas, que no excedan de un total de__ tratamientos y sin que transcurran más de 30 días del primer tratamiento. No se me darán tratamientos adicionales sin mi consentimiento por escrito.

Se han considerado otros métodos de tratamiento y alternativas (tales como sicoterapia y/o medicamentos) y, al presente, mi doctor no los recomienda porque

MEJORAMIENTO: Entiendo que el ECT puede acabar con o reducir Ia depresión, agitación y pensamientos inquietantes. En mi caso, es posible que Ia mejoría sea permanente; que no haya mejoria, o que Ia mejoría dure sólo unos cuantos meses. Sin este tratamiento, mi estado puede mejorar, empeorar o continuar con un ligera cambio o sin cambio alguno.

RIESGOS Y EFECTOS SECUNDARIOS: Entiendo que hay división de opiniones en Io que respecta a Ia eficacia de este tratamiento así como dudas de cómo funciona este procedimiento.

Entiendo, igualmente, que este tratamiento puede tener efectos secundarios breves: dolores de cabeza, dolencia de los músculos y confusión.

Puede haber pérdida de Ia memoria que puede durar menos de una hora o es posible que resulte una pérdida de Ia memoria esporádica permanentemente. La pérdida de Ia memoria y Ia confusión pueden aminorarse con el uso unilateral (de un sólo lado) de estimulaciones (corrientes) eléctricas en el cerebro, en vez de recibir Ia estimulación (corriente) de forma bilateral (en los dos lados).

Durante estos tratamientos se utilizarán anestesia y relajantes musculares para evitar lesiones a daños accidentales. Se administrará oxigeno para reducir al mínimo el riesgo pequeño que existe de que pudiera ocurrir un malfuncionamiento del corazón, pulmón, o cerebro o inclusive Ia muerte, como resultado de Ia anestesia o el tratamiento.

Mi doctor indica que yo tengo las siguientes condiciones que aumentarán los riesgos en ml caso:

ENGO EL DERECHO DE ACEPTAR O RECHAZAR ESTE TRATAMIENTO. SI DOY MI CONSENTIMIENTO, TENGO EL DERECHO DE REVOCAR ESTE CONSENTIMIENTO POR CUALQUIER RAZON, Y EN CUALQUIER TIEMPO ANTES DE, O ENTRE TRATAMIENTOS.

El doctor_____me ha explicado Ia infarmación que aparece arriba a mi satisfacción. Por Io menos han transcurrido 24 horas desde que Ia información arriba mencionada me fue explicada. He leido cuidadosamente, o se me ha leído este formulario y Io entiendo así como Ia información que se me ha proporcionado.

POR LA PRESENTE DOY Ml CONSENTIMIENTO PARA ECT

Firma _____ Fecha y hora _____ Firma del testigo _____

DHCS 1800 SP (06/2013)

Appendix E
PROCEDURE FOR INVOLUNTARY ELECTROCONVULSIVE TREATMENT (ECT)

PROCEDURE FOR INVOLUNTARY ELECTROCONVULSIVE TREATMENT (ECT)
(Including Any Client Under Guardianship or LPS Conservatorship 18 Years of Age or Older)

I. The client's outpatient or inpatient treating psychiatrist:

1. Determines the need for electroconvulsive treatment (ECT) based on community standard guidelines

(usually severe primary affective disorder, psychotic catatonia):

- *Not responsive to less intensive forms of treatment, or*
- *When the client is unable to tolerate other forms of treatment, or*
- *When the client's psychiatric illness is so severe that relief of symptoms is medically urgent.)*

and documents this in the client's medical record;

2. Prepares a written supplement to the standard consent form containing details pertaining to the particular client. (*This supplemented form must specify a maximum number of treatments over a maximum period not to exceed 30 days.*) This signed documentation includes clinical reasons for the procedure, and a statement that all reasonable treatment modalities have been carefully considered, that the treatment is definitely indicated and is the least drastic alternative for this client at this time (Form MH:300);

3. Determines that in his/her opinion this client is incapable of written informed consent: Written informed consent requires that a person knowingly and intelligently, without duress or coercion, clearly and expressly manifests consent to the treating psychiatrist and in writing on the standard ECT consent form. A person is incapable of written informed consent if he/she cannot understand or intelligently act on the information given;

4. Requests that a Review Committee of two board eligible or board-certified Psychiatrists (or Neurologist) reviews the treatment proposal; committee members may not be personally involved in the client's treatment *(requests go to the treating facility, either inpatient or outpatient, for committee members. Both members of the Review Committee may be appointed by the treating facility from a list certified by the facility's Medical Director/Chief of Staff. The Local Mental Health Director approves the Medical Directors as his/her designee, both committee members must review the medical record, and at least one must personally examine the client)*. If both members of the committee agree the proposed ECT is appropriate and necessary, both document that finding in the treatment record and complete form entitles, "Review Committee – Electroconvulsive Treatment for Involuntary Patients" [Form HHSA:MHS-195 (02/00)]. (*If one disagrees with the proposed ECT, do not proceed*), then;

5. Has a petition filed with the Superior Court; the Court holds evidentiary hearing within three business days to determine client's capacity; client attends hearing with Legal Counsel (*The client may appoint Counsel or the Court may be petitioned to appoint the Public Defender as a precedent to a decision regarding ECT*).

II. The Superior Court finds the client incapable of written informed consent. A responsible relative, guardian, or Lanterman-Petris-Short Conservator of Person reviews recommendation of treating psychiatrist and makes election for ECT. This responsible person may refuse consent, or may later act for client in withdrawing consent (If the Court finds the client competent to give informed consent for ECT, do not proceed).

The treating psychiatrist refers the client to the psychiatrist who will perform ECT, if the ECT is not to be given by the treating psychiatrist. Medical evaluation is documented as required by the facility policy, informed consent is confirmed, and treatment is scheduled. All steps are to be fully documented in the client's treatment record. All pertinent documentation and medical evaluation

results, including completed informed consent, must be provided to the facility where the ECT is to be given (*If more treatments are required than were authorized in the above steps, the procedure must be reinitiated beginning with I.1*).

III. The consenting party may withdraw Informed Consent for ECT at any time prior to treatment.

IV. If ECT is to be paid from the Mental Health budget for indigent care, then prior authorization is required from the Local Mental Health Director or his/her designee. This authorization is contingent on meeting the criteria for indigent services (UMDAP).

If ECT is to be paid for by specialty mental health Medi-Cal funds, then prior authorization is required from the Administrative Service Organization Medical Director or the Local Mental Health Director (or designee). This authorization is contingent on clinical considerations relevant to Utilization Management under Medi-Cal regulations.

It is expected that all alternate client resources and entitlements will be utilized for ECT and the required medical
evaluation prior to authorizing the utilization of County specialty mental health resources.

V. Outpatient ECT may be approved under the following circumstances:

1. The client has begun ECT on an inpatient basis and requires continuing treatments, but no longer requires inpatient care, **or**

2. The client is an outpatient who requires ECT but does not meet criteria for inpatient admission, **and**

3. The client has sufficient community support for safe outpatient ECT. Support may be provided by the client's personal resources (such as, family and friends) or may be arranged by the treating psychiatrist or treatment team, such as home health services, if available.

Appendix F

REVIEW COMMITTEE – ELECTROCONVULSIVE TREATMENT FOR INVOLUNTARY CLIENTS

Review Committee – Electroconvulsive Treatment for Voluntary Clients

We, the undersigned Psychiatrists, have reviewed the treatment record of

_____, which include the psychiatric history and
(Client)

examination by_____, MD, and specific statements by
(Treating Psychiatrist)

_____, MD, indicating the reason for the choice
(Treating Psychiatrist)

of this treatment procedure, that all reasonable treatment modalities have been carefully considered, that electroconvulsive treatment is definitely indicated and is the least drastic alternative available for this client at this time.

Based on a personal examination of the client and/or my review of the client's medical record (one Review Committee member only), we agree with the opinion and recommendation of the client's treating psychiatrist that electroconvulsive treatment is the treatment of choice for the welfare of this client and that this client is not able to give informed consent for this procedure.

Date:_____ Consultant Psychiatrist:_____
(Appointed by facility)

Date:_____ Consultant Psychiatrist:_____
(Approved by Behavioral Health Services Director)

HHSA: MHS – 195 (06/2016)

County of San Diego
Health and Human Services Agency
Behavioral Health Services

Appendix G
SAN DIEGO COUNTY FUNDED LONG-TERM CARE CRITERIA

San Diego County Funded Long-Term Care Criteria

Long-Term Care (LTC) for San Diego County Medi-Cal eligible individuals over the age of 18 may take place in several types of facilities. All are approved and funded by the County of San Diego's Department of Behavioral Health Services. The County of San Diego contracts with Optum as their Administrative Service Organization (ASO) to clinically review and authorize reimbursement for admission and continued treatment in LTC facilities.

The following guiding principles apply to all LTC levels of care:

- **Care Should Promote the Client's Recovery:** Clients have the right to be treated with respect and recognition of their dignity, strengths, preferences, right to privacy, and unique path to recovery. Clients also have the right to information that will inform decision-making, promote participation in treatment, enhance self-management, and support broader recovery goals.
- **Care Should Be Accessible:** Optimal clinical outcomes result when access to the most appropriate and available level of care is facilitated at admission and when transitioning between levels of care. A Client's transition between levels of care should be timely and occur in a safe manner, and pertinent clinical information should be communicated to provider at the next level of care.
- **Care Should Be Appropriate:** Optimal clinical outcomes result when evidence-based treatment is provided in an appropriate level of care, and the proposed care stems from the Client's current condition. The level of care should be structured and intensive enough to safely and adequately treat a Client's presenting problem and support his/her recovery. Treatment planning should take into account significant variables such as the Client's current clinical need, age and level of development, whether the proposed services are covered in the Client's benefit plan, whether the proposed forms of treatment are evidence-based, whether the proposed services are available in or near the Client's community, whether community resources such as self-help and peer support groups, consumer-run services, and preventive health programs can augment treatment, and whether a less restrictive setting in which a client may be effectively treated is unavailable.
- **Care Should Be Effective:** There must be a reasonable expectation that evidence-based treatment delivered in the appropriate level of care will improve the Client's presenting problems within a reasonable period of time. Improvement in this context is measured by weighing the effectiveness of treatment and the risk that the Client's condition is likely to deteriorate or relapse if treatment in the current level of care were to be discontinued. Improvement must also be understood within a recovery framework where services support movement toward a full life in the community.

Institute of Mental Disease (IMD): A 24-hour institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, and care of persons with mental disorders. IMDs are licensed as a Mental Health Rehabilitation Center (MHRC) or a Specialized Treatment Program (STP).

The client must meet the following required criteria for a county funded IMD bed:

1. Is a current resident of the State of California and has Medi-Cal eligibility for the County of San Diego and currently receives Social Security Income (SSI) or a copy of completed SSI application is submitted and this has been approved by the County Case Manager..
2. Is between the ages of 18-64 for an MHRC or is age 18 and above for a STP.
3. Is not entitled to comparable services through other systems, i.e. Veterans Affairs (VA), Regional Center, or private insurance.
4. Cannot be safely managed in a less restrictive level of care. Documentation is provided to show that all other alternatives including ASP Board and Care, traditional Board and Care, FSP case management, and case management have been attempted or there is documentation that these alternatives are not able to meet the client's needs.
5. Has the potential to be helped by a residential psychosocial rehabilitation treatment program and the potential to progress to a less restrictive level of care.
6. Is gravely disabled as determined by the establishment of a temporary or permanent, public or private LPS Conservatorship by Superior Court.
7. Is currently being treated in an LPS psychiatric hospital or is in a Secure Facility/Long Term Care (SF/ LTC) bed currently funded by San Diego County.
8. Is assigned to or will be assigned to a Case Management program funded by the County of San Diego.
9. Has an adequately documented Title 9, DSM IV-TR Primary diagnosis of a serious, persistent, major mental disorder or an eating disorder; the primary diagnosis cannot be a substance abuse related disorder.
    a. The symptoms must not be primarily a manifestation of a developmental disorder, dementia, or TBI.
    b. May have a substance abuse diagnosis as a concurrent diagnosis.
    c. May also have a concurrent Personality Disorder diagnosis, but diagnosis alone is not sufficient to meet criteria.
10. Is not at imminent risk of serious harm to self or others.
11. Has a tuberculosis (TB) clearance within thirty days of application.
12. Is medically appropriate as determined by applicable IMD and MHRC regulations.

And the client must meet at least <u>one</u> of the following clinical criteria (these criteria are not intended for use solely as a long-term solution to maintain stability acquired during treatment in a residential facility/ program):

a. The client's psychosocial functioning has deteriorated to the degree that the client is at risk for being unable to safely and adequately care for themselves in the community or at a less restrictive setting and there is a reasonable expectation that treatment will produce a higher level of functioning.
b. A lower level of care in which a client may be effectively treated is unavailable, an intensified schedule of ambulatory care or a change in the treatment plan has not proven effective, or community support services that might augment ambulatory mental health services and pre-empt the need for IMD level of care is unavailable, insufficient, or inadequate.

Exceptions to criteria may be made by Optum Medical Director after consultation with County Medical Director and COR.

San Diego County Funded Skilled Nursing Facility (SNF): A healthcare facility with the staff and equipment to provide skilled nursing care, rehabilitation, custodial care, and other related health services to patients who need nursing care, but do not require hospitalization.

The client must meet the following required criteria for San Diego County funded SNF:

1. Is a current resident of the State of California and has Medi-Cal eligibility for the County of San Diego.
2. Is at least 18 years of age.
3. Is not entitled to comparable services through other systems, i.e. Veterans Affairs (VA), Regional Center, Medi-Care, or private insurance.
4. Cannot be safely managed in a less restrictive level of care. Documentation is provided to show that all other alternatives including Augmented Service Program Board and Care, traditional Board and Care, Full Service Partnership case management, and traditional case management have been attempted or there is documentation that these alternatives alone are not able to meet the client's needs.
5. Clients that appear to meet criteria to be covered by a MCP must be referred to the MCP for determination prior to be considered for County Funded SNF. Clients with no or minimal medical acuity conditions will not require prior denial determination from the MCP.
6. Client's primary focus of treatment is not a physical health condition that would require skilled nursing care.
7. Is currently being treated in an LPS psychiatric hospital or is in an SNF/LTC bed currently funded by San Diego County.
8. Requires 24/7 residential care with both a nursing component and a psychiatric component.
    a. IMD level of care was deemed as inappropriate level of care due to physical health needs, age, or not currently able to participate in a 21 hour per week psychosocial rehabilitation program.
9. Has exhibited the need for this level of care based on the client either being gravely disabled as determined by the establishment of a temporary or permanent, public or private LPS Conservatorship by the Superior Court or is assigned to or will be assigned to a Case Management program funded by the County of San Diego.
10. Has an adequately documented Title 9, DSM IV-TR Primary diagnosis of a serious, persistent, major mental disorder or an eating disorder; the primary diagnosis cannot be a substance abuse related disorder.
    a. The symptoms must not be primarily a manifestation of a developmental disorder, dementia, or TBI.
    b. May have a substance abuse diagnosis as a concurrent diagnosis.
11. May also have a concurrent Personality Disorder diagnosis, but diagnosis alone is not sufficient to meet criteria. Is not at imminent risk of serious harm to self or others.
12. Has a tuberculosis (TB) clearance within thirty days of application.

And the client must meet at least <u>one</u> of the following clinical criteria:

a. The client's psychosocial functioning has deteriorated to the degree that the client is at risk for being unable to safely and adequately care for themselves in the community or at a less restrictive setting.
b. A lower level of care in which a client may be effectively treated is unavailable, an intensified schedule of ambulatory care or a change in the treatment plan has not proven effective, or community support services that might augment ambulatory mental health services and pre-empt the need for SNF Treatment is unavailable, insufficient, or inadequate.

Exceptions to criteria may be made by Optum Medical Director after consultation with County Medical Director and COR.

San Diego County Skilled Nursing Facility (SNF) Patch: An additional daily rate paid by San Diego County to contracted SNFs that have agreed to provide additional mental health services to San Diego County beneficiaries.
The client must meet the following required criteria for San Diego County funded SNF Patch:

1. Is a current resident of the State of California, has Medi-Cal eligibility for the County of San

Diego, and has either Medi-Cal Managed Care Plan (MCP) or County Funded SNF program which will pay the daily rate for the SNF level of care.

2. Is at least 18 years of age.
3. Is not entitled to comparable services through other systems, i.e. Veterans Affairs (VA), Regional Center, Medi-Care, or private insurance.
4. Cannot be safely managed in a less restrictive level of care. Documentation is provided to show that all other alternatives including ASP Board and Care, traditional Board and Care, FSP case management, and case management have been attempted or there is documentation that these alternatives are not able to meet the client's needs.
5. Documentation from the LPS facility showing attempts were made to place client at all other appropriate SNF facilities.
6. Is currently being treated in an LPS psychiatric hospital or is in an SF/LTC bed currently funded by San Diego County.
7. Requires 24/7 residential care with both a nursing component and a psychological component.
    a. IMD level of care was deemed as inappropriate level of care due to physical health needs, age, or not currently able to participate in a 21 hour per week psychosocial rehabilitation program.
8. Is gravely disabled as determined by the establishment of a temporary or permanent, public or private LPS Conservatorship by Superior Court.
9. Is assigned to or will be assigned to a Case Management program funded by the County of San Diego.
10. Has an adequately documented Title 9, DSM IV-TR Primary diagnosis of a serious, persistent, major mental disorder or an eating disorder; the primary diagnosis cannot be a substance abuse related disorder.
    a. The symptoms must not be primarily a manifestation of a developmental disorder, dementia, or TBI.
    b. May have a substance abuse diagnosis as a concurrent diagnosis.
    c. May also have a concurrent Personality Disorder diagnosis, but diagnosis alone is not sufficient to meet criteria.
11. Is not at imminent risk of serious harm to self or others.
12. Has a tuberculosis (TB) clearance within thirty days of application.
13. Has the potential to benefit from psychosocial programming offered by the SNF.

And the client must meet at least <u>one</u> of the following clinical criteria (these criteria are not intended for use solely as a long-term solution to maintain stability acquired during treatment in a residential facility/program):

a. The client's psychosocial functioning has deteriorated to the degree that the client is at risk for being unable to safely and adequately care for themselves in the community or at a less restrictive setting and there is a reasonable expectation that treatment will produce a higher level of functioning.
b. A lower level of care in which a client may be effectively treated is unavailable, an intensified schedule of ambulatory care or a change in the treatment plan has not proven effective, or community support services that might augment ambulatory mental health services and pre-empt the need for SNF Treatment is unavailable, insufficient, or inadequate.

Exceptions to criteria may be made by Optum Medical Director after consultation with County Medical Director and COR.

Neurobehavioral Health Patch: A Skilled Nursing Facility that provides specialized neurobehavioral treatment and care for San Diego residents who are diagnosed with Traumatic Brain Injury (TBI) or Neuro-Cognitive Impairment (NCI) and a severe and persistent mental illness. An additional daily rate is paid to the facility by San Diego County.

The client must meet the following required criteria for a San Diego County funded NBU Patch:

1. Is a current resident of the State of California, has Medi-Cal eligibility for the County of San Diego, and has either a Medi-Cal Managed Care Plan (MCP) or the County Funded SNF program which will pay the daily rate for the SNF level of care.
2. Is at least 18 years of age.
3. Is not entitled to comparable services through other systems, i.e. Veterans Affairs (VA), Regional Center, or private insurance.
4. Cannot be safely managed in a less restrictive level of care. Documentation is provided to show that all other alternatives including ASP Board and Care, traditional Board and Care, FSP case management, and case management have been attempted or there is documentation that these alternatives are not able to meet the client's needs.
5. Is currently being treated in an LPS psychiatric hospital or is in a SF/LTC bed currently funded by San Diego County. Documentation from the LPS facility showing attempts were made to place client at all other appropriate SNF facilities including SNF Patch placement.
6. Requires 24/7 residential care with both a nursing component and a psychological component.
    a. IMD level of care was deemed as inappropriate level of care due to physical health needs, age, or not currently able to participate in a 21 hour per week psychosocial rehabilitation program.
7. Is gravely disabled as determined by the establishment of a temporary or permanent, public or private LPS Conservatorship by Superior Court.
8. Is assigned to or will be assigned to a Case Management program funded by the County of San Diego.
9. Has an adequately documented Title 9, DSM IV-TR Primary diagnosis of a serious, persistent, major mental disorder or an eating disorder; the primary diagnosis cannot be a substance abuse related disorder.
    a. The symptoms must not be primarily a manifestation of a developmental disorder, dementia, or TBI.
    b. May have a substance abuse diagnosis as a concurrent diagnosis.
    c. May also have a concurrent Personality Disorder diagnosis, but diagnosis alone is not sufficient to meet criteria.
10. Is not at imminent risk of serious harm to self or others.
11. Has a tuberculosis (TB) clearance within thirty days of application.
12. Have a diagnosis of Traumatic Brain Injury (TBI) or Neuro-Cognitive Impairment (NCI) and a pre-existing diagnosis of a severe and persistent mental illness. There must be documented evidence that the mental health diagnosis existed prior to the TBI or NCI.

And the client must meet at least <u>one</u> of the following clinical criteria (these criteria are not intended for use solely as a long-term solution to maintain stability acquired during treatment in a residential facility/ program):

a. The client's psychosocial functioning has deteriorated to the degree that the client is at risk for being unable to safely and adequately care for themselves in the community or at a less restrictive setting.
b. A lower level of care in which a client may be effectively treated is unavailable, an intensified schedule of ambulatory care or a change in the treatment plan has not proven effective, or community support services that might augment ambulatory mental health services and pre-empt the need for SNF Treatment is unavailable, insufficient, or inadequate.

Exceptions to criteria may be made by Optum Medical Director after consultation with County Medical Director and COR.

Specialized Residential Treatment: A Residential Facility for San Diego residents who are diagnosed with a severe and persistent mental illness. These facilities are licensed as an Adult Residential Facility (ARF) and provide a higher level of care than an Augmented Services Board and Care. These facilities provide psychosocial programming and have clinicians on staff.
The client must meet the following required criteria for admission tot a Specialized Residential Treatment facility:

1. Is a current resident in a County funded LTC residential program (IMD, SNF Patch, County Funded SNF, NBU Patch, or State Hospital).
2. Is referred by the treatment team at the County funded LTC residential program.
3. Is a current resident in the State of California and have Medi-Cal eligibility for the County of San Diego.
4. Has SSI funding.
5. Is not entitled to comparable services through other systems, i.e. Veterans Affairs (VA), Regional Center, or private insurance.
6. Is assigned to a Case Management program funded by the County of San Diego.
7. Documentation is provided to show that all other alternatives including ASP Board and Care, traditional Board and Care, FSP case management, and case management have been attempted or there is documentation that these alternatives are not able to meet the client's needs.
8. Is not able to be maintained at a less restrictive level of care.
9. Has an adequately documented Title 9, DSM IV-TR Primary diagnosis of a serious, persistent, major mental disorder or an eating disorder; the primary diagnosis cannot be a substance abuse related disorder.
    a. The symptoms must not be primarily a manifestation of a developmental disorder, dementia, or TBI.
    b. May have a substance abuse diagnosis as a concurrent diagnosis.
    c. May also have a concurrent Personality Disorder diagnosis, but diagnosis alone is not sufficient to meet criteria.
10. Has the potential to participate in an intensive psychosocial rehabilitation treatment program and the potential to progress to a less restrictive level of care.
11. Is gravely disabled as determined by the establishment of a temporary or permanent, public or private LPS Conservatorship by Superior Court.
12. Has a tuberculosis (TB) clearance within thirty days of application.
13. Has absence of current extreme dangerousness to self or others. This includes absence of chronic or recurrent episodes of assaultive behavior.

And the client must meet at least <u>one</u> of the following clinical criteria (these criteria are not intended for use solely as a long-term solution to maintain stability acquired during treatment in a residential facility/ program):

a. The client's psychosocial functioning has deteriorated to the degree that the client is at risk for being unable to safely and adequately care for themselves in the community or at a less restrictive setting.
b. A lower level of care in which a client may be effectively treated is unavailable, an intensified schedule of ambulatory care or a change in the treatment plan has not proven effective, or community support services that might augment ambulatory mental health services and pre-empt the need for SNF Treatment is unavailable, insufficient, or inadequate.

Exceptions to criteria may be made by Optum Medical Director after consultation with County Medical Director and COR.

State Hospital: A California State operated psychiatric hospital for adults. The hospital provides evaluation and treatment for individuals with serious and persistent mental illness. This is the highest level of care available to San Diego County beneficiaries and serves clients who are unable to be maintained at all other levels of care.

The client must meet the following required criteria for San Diego County funded bed at a California State Hospital:

1. Is a current resident of the State of California and has Medi-Cal eligibility for the County of San Diego.
2. Is at least 18 years of age.
3. Is not entitled to comparable services through other systems, i.e. Veterans Affairs (VA), Regional Center, or private insurance.
4. Cannot be safely managed in a less restrictive level of care.
5. Is currently being treated in an LPS psychiatric hospital or is in a SF/LTC bed currently funded by San Diego County.
6. Is on LPS Permanent Conservatorship.
7. Is assigned to or will be assigned to a Case Management program funded by the County of San Diego.
8. Has an adequately documented Title 9, DSM IV-TR Primary diagnosis of a serious, persistent, major mental disorder or an eating disorder; the primary diagnosis cannot be a substance abuse related disorder.
    a. The symptoms must not be primarily a manifestation of a developmental disorder, dementia, or TBI.
    b. May have a substance abuse diagnosis as a concurrent diagnosis.
    c. May also have a concurrent Personality Disorder diagnosis, but diagnosis alone is not sufficient to meet criteria.
9. Is a current or recurrent danger to self or others, which includes chronic or recurrent episodes of assaultive or suicidal behavior. Documentation must show that assaultive behavior is a result of psychosis that has been resistant to treatment rather than antisocial behavior, Dementia, or Traumatic Brain Injuries (TBI).
10. Has a tuberculosis (TB) clearance within thirty days of application.
11. Has been tried on multiple medication trials and they have been insufficient to resolve or reduce the presenting symptoms to the point the client could be placed at a lower level of care.
12. Is approved for admission to State Hospital by the San Diego County LTC Coordinator.

And the client must meet at least <u>one</u> of the following clinical criteria (these criteria are not intended for use solely as a long-term solution to maintain stability acquired during treatment in a residential facility/ program):

a. The client's psychosocial functioning has deteriorated to the degree that the client is at risk for being unable to safely and adequately care for themselves in the community or at a less restrictive setting and there is a reasonable expectation that treatment will produce a higher level of functioning.
b. A lower level of care in which a client may be effectively treated is unavailable, an intensified schedule of ambulatory care or a change in the treatment plan has not proven effective, or community support services that might augment ambulatory mental health services and pre-empt the need for State Hospital Treatment is unavailable, insufficient, or inadequate.

Exceptions to criteria may be made by Optum Medical Director after consultation with County Medical Director and COR.

Continued Stay Criteria by Level of Care

Continued Stay Criteria: IMD, NBU Patch, SNF Patch, Specialized Residential Treatment, and State Hospital

Facilities will submit review documentation to Optum on a quarterly basis for all clients at this level of care to request continued stay authorization.

The client must meet all of the following required criteria for continued stay in a San Diego County Funded SF/LTC facility:

1. The client continues to meet the admission criteria for the current level of care.
2. The client continues to present with symptoms and/or history that demonstrate a significant likelihood of deterioration in functioning/relapse if transitioned to a less intensive level of care.
3. The treatment being provided is appropriate and of sufficient intensity to address the client's condition and support the client's movement toward recovery.
4. The client is actively participating in treatment or is reasonably likely to participate after an initial period of stabilization and/or motivational support.
5. The treatment plan is accompanied by ongoing documentation that the client's symptoms are being addressed by active interventions; the interventions focus on specific, realistic, achievable treatment and recovery goals that are appropriate to the client's strengths, problems and situation; and designed to prevent relapse and measure progress toward discharge.
6. Measurable and realistic progress has occurred or there is clear compelling evidence that continued treatment at the current level of care is required to prevent acute deterioration or exacerbation that would then require a higher level of care. Lack of progress is being addressed by an appropriate change in the treatment plan or other intervention to engage the client.
7. The client requires the current level of care in order to move toward recovery.
8. There is an appropriate discharge plan to a less restrictive level of care or for termination of treatment that takes into account the client's recovery goals and preferences and allows for treatment gains to be maintained/enhanced.

And the client must meet at least <u>one</u> of the following clinical criteria (these criteria are not intended for use solely as a long-term solution to maintain stability acquired during treatment in a residential facility/ program):

a. The client's psychosocial functioning has deteriorated to the degree that the client is at risk for being unable to safely and adequately care for themselves in the community or at a less restrictive setting and there is a reasonable expectation that treatment will produce a higher level of functioning.
b. A lower level of care in which a client may be effectively treated is unavailable, an intensified schedule of ambulatory care or a change in the treatment plan has not proven effective, or community support services that might augment ambulatory mental health services and pre-empt the need for this level of care is unavailable, insufficient, or inadequate.

Exceptions to criteria may be made by Optum Medical Director after consultation with County Medical Director and COR.

Continued Stay Criteria: County Funded SNF

Initial concurrent review will be conducted 90 days from date of admission. Subsequent concurrent reviews will be at a frequency determined based on clinical presentation. The review will be no less than 30 days and no more than 180 days from last review; dependent on clinical documentation, level of impairment, and progress towards discharge plan.

The client must meet all of the following required criteria for continued stay in a San Diego County Funded SF/ LTC facility:

1. The client continues to meet the admission criteria for the current level of care.
2. The client continues to present with symptoms and/or history that demonstrate a significant likelihood of deterioration in functioning/relapse if transitioned to a less intensive level of care.
3. The treatment being provided is appropriate and of sufficient intensity to address the client's condition and support the client's movement toward recovery.
4. The treatment plan is accompanied by ongoing documentation that the client's symptoms are being addressed by active interventions; the interventions focus on specific, realistic, achievable treatment and recovery goals that are appropriate to the client's strengths, problems and situation; and designed to prevent relapse and measure progress toward discharge.
5. Measurable and realistic progress has occurred or there is clear compelling evidence that continued treatment at the current level of care is required to prevent acute deterioration or exacerbation that would then require a higher level of care.
6. The client requires the current level of care in order to move toward recovery.
7. There is an appropriate discharge plan to a less restrictive level of care or for termination of treatment that takes into account the client's recovery goals and preferences and allows for treatment gains to be maintained/enhanced.
8. Responsible Managed Care Plan re-evaluated client, as clinically indicated or as appropriate, and written documentation is provided indicating that the client does not meet the Managed Care Plan's SNF Level of Care criteria.
9. Client's primary focus of treatment is not a physical health condition that would require skilled nursing care.

And the client must meet at least <u>one</u> of the following clinical criteria:

a. The client's psychosocial functioning has deteriorated to the degree that the client is at risk for being unable to safely and adequately care for themselves in the community or at a less restrictive setting and there is a reasonable expectation that treatment will produce a higher level of functioning.
b. A lower level of care in which a client may be effectively treated is unavailable, an intensified schedule of ambulatory care or a change in the treatment plan has not proven effective, or community support services that might augment ambulatory mental health services and pre-empt the need for this level of care is unavailable, insufficient, or inadequate.

Exceptions to criteria may be made by Optum Medical Director after consultation with County Medical Director and COR.

Appendix H
REQUIRED DOCUMENTATION AND REFERRAL FORM FOR SF/LTC REFERRAL PACKETS

Required Documentation and Referral Form for SF/LTC Referral Packets for County Funded SNF

1. SF/LTC Referral Form with attending psychiatrist's order for SF/LTC (attached).
2. Facility Face Sheet.
3. Proof of current Medi-Cal coverage (an Automated Eligibility Verification System [AEVS] strip from the facility business office) for San Diego County.
4. Most recent Court Investigation Report for San Diego County LPS Conservatorship.
5. Complete Psychiatric Assessment from current facility including psychiatric history, substance abuse history and history of self-destructive or assaultive behavior.
6. Cognitive assessment (e.g. Mini-Cog, MDS).
7. Physical and Medical History from current stay.
8. Nursing Assessment from current stay.
9. Social Work Assessment and Notes from current stay.
10. One week of progress notes including nursing, group, and psychiatrist.
11. Medication including Medication Administration Record showing medication compliance and information on medication changes.
12. Lab reports.
13. Results of purified protein derivative (PPD) (tuberculosis [TB] test) or chest x-ray done.
14. Written recommendation from the assigned Case Management program funded by the County of San Diego. If client is not assigned a Case Management program funded by the County of San Diego, then documentation that client will be assigned to a Case Management program funded by the County of San Diego

Attachment:
A: Secure Facility/Long Term Care (SF/LTC) Referral for San Diego Clients

(Please fax packets with the attached referral form to Optum at 888.687.2515)

Documentation Needed for SF/LTC Referral Packets For IMD

1. SF/LTC Referral Form with attending psychiatrist's order for SF/LTC attached.
2. Referring Facility Face Sheet.
3. Proof of current Medi-Cal coverage (an Automated Eligibility Verification System [AEVS] strip from the hospital business office) for San Diego County.

4. Proof of current SSI and "Notice to Representative Payee" signed by payee.

5. Most recent Court Investigation Report for San Diego County LPS Conservatorship.

6. Complete Psychiatric Assessment from current hospitalization including psychiatric history, substance abuse history and history of self destructive or assaultive behavior. If individual has been hospitalized more than thirty days, this information must be updated with course of treatment and current acuity.

7. Mini-Cog exam completed within seven days of referral for SF/LTC.

8. Physical and Medical History from current stay. If individual has been hospitalized more than thirty days, this information must be updated with course of treatment and current acuity.

9. Nursing Assessment from current stay.

10. Social Work Assessment and Notes from current stay.

11. One week of progress notes including nursing, group, and psychiatrist.

12. Medications including Medication Administration Record showing medication compliance and information on medication changes.

13. Lab reports from current stay.

14. Results of purified protein derivative (PPD) (tuberculosis [TB] test) or chest x-ray done within 30 days of application.

15. Written recommendation from the assigned Case Management program funded by the County of San Diego. If client is not assigned a Case Management program funded by the County of San Diego, then documentation that client will be assigned to a Case Management program funded by the County of San Diego.

Note: Referrals are made when a client is receiving acute care treatment while in the Behavioral Health Unit (BHU) of an LPS hospital. All referrals are initiated by the Attending Psychiatrist and the hospital Social Work department provides the needed documentation to Optum.

Documentation Needed for SF/LTC Referral Packets for SNF Patch or NBU Patch

1. SF/LTC Referral Form with attending psychiatrist's order for SF/LTC attached.

2. Referring Facility Face Sheet.

3. Proof of current Medi-Cal coverage (an Automated Eligibility Verification System [AEVS] strip from the hospital business office) for San Diego County.

4. Proof of current SSI and "Notice to Representative Payee" signed by payee.

5. Most recent Court Investigation Report for San Diego County LPS Conservatorship.

6. Complete Psychiatric Assessment from current hospitalization including psychiatric history, substance abuse history and history of self destructive or assaultive behavior. If individual has been hospitalized more than thirty days, this information must be updated with course of treatment and current acuity.

7. Mini-Cog exam completed within seven days of referral for SF/LTC.

8. Physical and Medical History from current stay. If individual has been hospitalized more than thirty days, this information must be updated with course of treatment and current acuity.

9. Nursing Assessment from current stay.

10. Social Work Assessment and Notes from current stay.

11. One week of progress notes including nursing, group, and psychiatrist.

12. Medications including Medication Administration Record showing medication compliance and information on medication changes.

13. Lab reports from current stay.

14. Results of purified protein derivative (PPD) (tuberculosis [TB] test) or chest x-ray done within 30 days of application.

15. Written recommendation from the assigned Case Management program funded by the County of San Diego. If client is not assigned a Case Management program funded by the County of San Diego, then documentation that client will be assigned to a Case Management program funded by the County of San Diego.

16. For SNF Patch: Call log documenting attempts at SNF placement and denials from in-county SNFs.

17. For NBU Patch: Documentation of a pre-existing severe and persistent mental illness that existed prior to the TBI.

Note: Referrals are made when a client is receiving acute care treatment while in the Behavioral Health Unit (BHU) of an LPS hospital. All referrals are initiated by the Attending Psychiatrist and the hospital Social Work department provides the needed documentation to Optum.

Documentation Needed for Referral to ARF

The following documentation needs to be submitted by the County Funded LTC facility making a referral to ARF Level of Care. Referrals are accepted from San Diego County Funded LTC facilities including IMDs, County Funded SNF, and SNF Patch. Forms can be found on at the Optum website at **www.optumsandiego.com**. Documentation can be submitted to the Optum LTC Fax line at 888 687-3515. Please call the LTC Provider Line at 800 798-2254 Option 3 then 5 with any questions.

1. SF/LTC Referral Form with attending psychiatrists order for ARF.
2. Referring facility face sheet.
3. Proof of current Medi-Cal coverage for San Diego County.

4. Proof of current SSI and "Notice to Representative Payee" signed by payee.
5. Copy of most recent BHA form from CCBH.
6. Current treatment plan.
7. Last three Quarterly Reviews that were submitted to Optum.
8. Last two months of IDT/treatment team meeting documentation.
9. Physical and medical history from current stay including nursing care plans.
10. Two weeks of progress notes including nursing, group and psychiatrist notes.
11. Medications including Medication Administration Record showing medication compliance and information on medication changes from past 30 days.
12. Lab reports as applicable to current treatment plan.
13. Written recommendation from assigned Case Management program funded by the County of San Diego. If client is not assigned to a Case Management program funded by the County of San Diego, then documentation that client will be assigned to a Case Management program funded by the County of San Diego.

Client must be on LPS Conservatorship. If conservatorship is public and documented in CCBH, Optum will add the most recent Court Investigation Report and Letters and Orders. If conservatorship is private, the packet must include the most recent Letters and Orders with current contact information for the private conservator, the Court Investigation Report, and a letter from the private conservator supporting the referral to ARF level of care.

Documentation Needed for State Hospital Referral

State Hospital referrals require that these documents be submitted in the following order. Please use dividers to identify the documents since document titles may differ from the language used by the state hospital.
Documentation needed by Optum:

- Referral Screening Form requesting State Hospital
- Case Manager Recommendation requesting State Hospital
- Documentation of San Diego County Medi-Cal (POS strip) or written statement from Case Manager that they believe client is eligible for Medi-Cal and that Case Management is taking responsibility for following up on the Medi-Cal status
- Documentation of SSI if not included on Case Manager Recommendation form or written statement from Case Manager that they believe client is eligible for Medi-Cal and that Case Management is taking responsibility for following up on the Medi-Cal status
- Electronic Short Doyle Form

Documentation needed by State Hospital:

DOCUMENT REQUIRED	YES	NO
1-PROOF of CONSERVATORSHIP or LEGAL STATUS*		
2-CONSENT FOR TREATMENT (MSH FORM) Signed by Conservator*		
3-COMPREHENSIVE ADMISSION/INITIAL PSYCHIATRIC EVALUATION Done by a Physician within the last 30 days*		
4-PHYSICIAN ORDERS, LAST 7 DAYS ONLY*		
5- MOST RECENT PHYSICAL EXAM AND MEDICAL HISTORY*		
6- LAB and DIAGNOSTIC RESULTS*		
7- PSYCHIATRIST'S PROGRESS NOTES, LAST 7 DAYS ONLY*		
8-PSYCHOSOCIAL HISTORY*		
9- NURSING NOTES LAST 7 DAYS ONLY*		
10-CURRENT MEDICATIONS AND DOSAGES*		
11-PPD-MOST RECENT		
12-ADVANCE HEALTH CARE DIRECTIVE		

SECURE FACILITY/LONG TERM CARE (SF/LTC) Referral for San Diego Clients

Level of care requested (Select one. A separate referral form is needed for each level of care):

☐ IMD ☐ SD County Funded SNF ☐ ARF ☐ SNF Patch ☐ NBU Patch ☐ State Hospital

Referring Facility:	Admit date:	Contact name:	Phone:	Fax:

Patient's Name:	DOB:	Age:

Marital:	Ethnic:	1st Language:	2nd Language:

☐ SSI	☐ Medicare	Allergies:
☐ SSA	☐ Regional Ctr	
☐ SSDI	☐ VA Benefit	TB Screen Date:
☐ Other	☐ Medi-Cal	TB Results:

Conservator: ☐ Public ☐ Private ☐ Temporary ☐ Permanent Date Established:

Name of Conservator/Court Investigator: Telephone #

Comments on Court Investigation:

Name of Case Manager: Telephone #

Name of Payee: Telephone #

If NO Payee, has an application been made for Payee Services? ☐ Yes ☐ Date of Application

Comments:

Diagnosis: Use DSM-IV-TR/ICD 10 Diagnosis and Other Clinical or Medical Considerations	Risk Factors	weak → strong				
Primary DX:	weak to strong	1	2	3	4	5
ICD 10 Code:	Suicidal Risk	☐	☐	☐	☐	☐
Other DX (Clinical or Medical):	AWOL Risk	☐	☐	☐	☐	☐
	Assaultive Risk	☐	☐	☐	☐	☐
	Drug/ETOH Risk	☐	☐	☐	☐	☐
	Sexual Hx Risk	☐	☐	☐	☐	☐

Comments on Risk Factors:

Dangerous Propensities:

Infectious Disease:

Reason for referral to this level of care:

Comments on current treatment:

History of prior hospitalization:

Living situation for past 12 months:

Legal issues. Note any legal issues including probation, warrants, or interaction with legal system.

Treating psychiatrist: Phone:

Printed name of psychiatrist:

Form updated August 3, 2015.

Please fax packets (with this referral form) to Optum at 888 687-2515

Appendix I
BENEFICIARY AND CLIENT PROBLEM RESOLUTION POLICY AND PROCESS

BENEFICIARY AND CLIENT PROBLEM RESOLUTION POLICY AND PROCESS

I. BENEFICIARY AND CLIENT PROBLEM RESOLUTION POLICY

In its commitment to honoring mental health consumer rights, the County of San Diego shall maintain a beneficiary and client problem resolution process, in compliance with State and Federal regulations, which provides a quality, impartial, and effective process for resolving consumer problems encountered while accessing or receiving mental health services. All County-operated and contracted providers shall be required by contract to cooperate with the problem resolution process as described herein. The full and timely cooperation of the provider shall be considered essential in honoring the client's right to an efficient problem resolution.

A. PROCESS

San Diego County Mental Health Services is committed to providing a quality, impartial, and effective process for resolving consumer complaints encountered while accessing or receiving mental health services. The process is designed to:

- Provide easy access
- Support the rights of individuals
- Be action-oriented
- Provide timely resolution
- Provide effective resolution at the lowest level
- Improve the quality of services for all consumers in the population

While the consumer is encouraged to present problems directly to the provider for resolution, when a satisfactory resolution cannot be achieved, one or more of the processes below may be used:

1) Grievance process
2) Appeal process (in response to an "action" as defined as: denying or limiting authorization of a requested service, including the type or level or service; reducing, suspending, or terminating a previously authorized service, denying, in whole or in part, payment for a service; failing to provide services in a timely manner, as determined by the Mental Health Plan (MHP) or; failing to act within the timeframes for disposition of standard grievances, the resolution of standard appeals or the resolution of expedited appeals.)
3) Expedited Appeal process (available in certain limited circumstances)
4) State Fair Hearing process--available to Medi-Cal beneficiaries who have filed an appeal through the County Mental Health Program (MHP) process and are dissatisfied with the resolution. The State Fair Hearing is also for clients whose grievance or appeal was not resolved timely in the MHP process (including an extension if permission was given), or no permission for an extension was given. In this instance, clients are not required to wait until the completion of the County MHP process to do so.

The Mental Health Problem Resolution process covers Medi-Cal beneficiaries, Severely Emotionally Disabled (SED) certified children through the Healthy Families program, and persons without Medi-Cal funds receiving County-funded mental health services. It is designed to meet the regulations in CCR Title 9, Division 1, Chapter 11, Subchapter 5, Section 1850.205 and 42 CFR Subpart F, Part 438.400. The procedures relating to children and youth served under AB 3632/2726 legislation will take precedence over this document. By law, Welfare and Institution (WI) Code WI 10950, the State Fair Hearing process, is only available to a Medi-Cal beneficiary.

B. OBJECTIVES

1. To provide the consumer with a process for independent resolution of grievances and appeals.
2. To protect the rights of consumers receiving mental health services, including the right to:
   - Be treated with dignity and respect,
   - Be treated with due consideration for his or her privacy,
   - Receive information on available treatment options in a manner appropriate to his or her condition and ability to understand,
   - Participate in decisions regarding his or her mental health care, including the right to refuse treatment,
   - Be free from any form of unnecessary restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation,
   - Request a copy of his or her medical records, and to request that an additional statement amending or correcting the information be included, and
   - Freely exercise these rights without adverse effects in the way providers treat him or her.
3. To protect the rights of consumers during grievance and appeal processes.
4. To assist individuals in accessing medically necessary, high quality, consumer-centered mental health services and education.
5. To respond to consumer concerns in a linguistically appropriate, culturally competent and timely manner.
6. To provide education regarding, and easy access to, the grievance and appeal process through widely available informational brochures, posters, and self-addressed grievance and appeal forms located at all provider sites.

C. BENEFICIARY and CLIENT RIGHTS DURING THE GRIEVANCE AND APPEAL PROCESS

1. Consumer concerns shall be responded to in a linguistically appropriate, culturally competent and timely manner.
2. Clients' rights and confidentiality shall be protected at all stages of the grievance and appeal process by all providers and advocates involved.

3. Consumers shall be informed of their right to contact the Jewish Family Service (JFS) Patient Advocacy Program regarding problems at inpatient and residential mental health facilities or the Consumer Center for Health Education and Advocacy (CCHEA) for problems with outpatient and all other mental health services, at any time for assistance in resolving a grievance or appeal. Medi-Cal beneficiaries shall also be informed of their right to request a State Fair Hearing.

4. Consumers of the MHP and persons seeking services shall be informed of the process for resolution of grievances and appeals. This includes information about the availability of the JFS Patient Advocacy Program and CCHEA, the programs that currently are contracted with the MHP to assist consumers with problem resolution, at the consumer's request. The information shall be available in the threshold languages and shall be given to the client at the point of intake to Mental Health Plan services, and upon request during the provision of services. Continuing clients must be provided with the information annually. Providers shall document the provision of this information.

5. The client may authorize another person or persons to act on his/her behalf. A client may select a provider as his or her representative in the appeal process. His or her representative, or the legal representative of a deceased client's estate, shall be allowed to be included as parties to an appeal.

6. A support person chosen by the client, such as family member, friend or other advocate may accompany them to any meetings or hearings regarding a grievance or appeal.

7. The client and/or his or her representative may examine the case file, including documents or records considered during the grievance or appeal process.

8. Consumers shall not be subject to any discrimination, penalty, sanction or restriction for filing a grievance or appeal. The consumer shall not be discouraged, hindered or otherwise interfered with in seeking or attempting to file a grievance or appeal.

9. Advocates shall treat clients, their chosen support persons, and all providers with courtesy and respect throughout the grievance resolution process.

    - Providers shall participate fully and in a timely manner in order to honor the client's right to an efficient, effective problem resolution process.
    - Medi-Cal beneficiaries, who have appealed through the MHP Beneficiary Problem Resolution process and are dissatisfied with the resolution, have the right to request an impartial review in the form of a State Fair Hearing within 120 calendar days of the decision whether or not the client received a Notice of Adverse Benefit Determination (NOABD). At a State Fair Hearing, a client has the opportunity to present his or her concerns to an

administrative law judge for a ruling. (See Section VIII for more information on the State Fair Hearings.)

- Clients who are Medi-Cal beneficiaries and who have a grievance or appeal which has not been resolved by the MHP within mandated timelines, and no client permission for an extension has been granted, may request a State Fair Hearing. They need not wait until the end of the County process before making the request.
- Quality of care issues identified as a result of the grievance and appeal process shall be reviewed by the MHP and the Quality Review Council for implementation of system changes, as appropriate.

D. CLIENT AND BENEFICIARY NOTIFICATION

1. Consumers shall be informed in a clear and concise way of the process for reporting and resolving grievances and appeals. This includes information on how to contact JFS Patient Advocacy and CCHEA. The information shall be available in the threshold languages and shall be given to the client at the point of intake to a program and, as appropriate, during the provision of services. Continuing clients must be provided with the information annually, and providers will document these efforts.
2. Notices in threshold languages describing mental health rights, as well as the grievance and appeal procedures, shall be posted in prominent locations in public and staff areas, including waiting areas of the provider location. Brochures with this information will also be available in these areas in the County's threshold languages.
3. Grievance/Appeal forms and self-addressed envelopes must be available for consumers at all provider sites in a visible location, without the consumer having to make a written or verbal request to anyone. This includes common areas of both locked and unlocked behavioral health units.
4. CCHEA and Patient Advocacy Program shall have interpreter services and toll-free numbers with adequate TDD/TTY, available at a minimum during normal business hours.
5. Under certain circumstances, when the MHP denies any authorization for payment request from a provider to continue specialty mental health services to a Medi-Cal beneficiary, the MHP must provide the Medi-Cal beneficiary with a Notice of Adverse Benefit Determination (NOABD), which informs the beneficiary of his or her right to request a State Fair Hearing, and the right to contact a representative from JFS or CCHEA.

II. INFORMAL PROBLEM RESOLUTION –available to all mental health clients

Consumers are encouraged to seek problem resolution at the provider level by speaking or writing informally to the therapist, case manager, facility staff, or other person involved in their care. Often this is the quickest way to both make the provider aware of the client's issue, as well as come to a satisfactory resolution. **However, no consumer shall be required to take the matter directly to the provider unless he or she chooses.**

In addition to, or instead of, bringing the issue directly to the individual provider, consumers may work directly with the supervisor or Program Director, who shall make efforts to resolve it. In attempting to reach resolution, and consistent with confidentiality requirements, the appropriate supervisor or Program Director shall utilize whatever information, resources and/or contacts the consumer agrees to.

III. GRIEVANCE PROCESS—available to all mental health clients

Any consumer of mental health services may express dissatisfaction with mental health services or their administration by filing a grievance through JFS Patient Advocacy (for inpatient and residential services) or the Consumer Center for Health Education and Advocacy (for outpatient and all other mental health services).

IV. GRIEVANCE PROCEDURES:

At any time, the consumer chooses, the consumer may contact CCHEA or JFS Patient Advocacy, as appropriate. CCHEA or JFS Patient Advocacy shall work to resolve the issue according to the following steps:

1. Client contacts JFS Patient Advocacy Program for issues relating to inpatient and other 24-hour-care programs, or CCHEA for issues relating to outpatient, day treatment and all other services, either orally or in writing, to file a grievance. A grievance is defined as an expression of dissatisfaction about anything other than an "action" (see Section IV for complete definition.).
   NOTE: If the client's concern is in regard to an "action" as defined, the issue is considered an "appeal" (see Section X for Definition) not a grievance. See "Appeal Process" in Section V below for procedure.
2. CCHEA or Patient Advocacy Program logs the grievance within one business day of receipt. The log shall include:
   - client name or other identifier,
   - date the grievance was received,
   - date it was logged, the nature of the grievance,
   - provider name,
   - whether or not the issue concerns a child.

   The log is to be maintained in a confidential location at CCHEA or JFS Patient Advocacy. The log content pertaining to the client shall be summarized in writing, if the client requests it.
3. CCHEA or Patient Advocacy Program provides the client a written acknowledgement of receipt of the grievance postmarked within five calendar days.
4. CCHEA or Patient Advocacy Program shall contact the provider involved in the grievance within two business days of receipt of the client's written permission to represent the client.
5. CCHEA or Patient Advocacy Program investigates the grievance.
   - CCHEA or JFS shall ensure that the person who makes the final determination

of the grievance resolution has had no prior or current involvement in the grievance determination.

- In cases where the CCHEA or JFS staff member has another existing relationship with the client or provider, that contractor's Program Director shall reassign the case or consult with the MHP QM Unit about conflict of interest of issues.
- The client's confidentiality shall be safeguarded per all applicable laws.

6. If the grievance is about a clinical issue, the decision maker must be a mental health professional with the appropriate clinical expertise in treating the client's condition.

7. All County-operated programs and contracted providers are required by contract to cooperate with the problem resolution process as it is described herein. The full participation and timely cooperation of the provider are essential to honoring the client's right to an efficient, effective problem resolution process. During the resolution of the client's grievance, CCHEA or Patient Advocacy staff will often find it necessary to discuss the issue with the providers involved, either in person or by phone at various points in the process. The expectation is that CCHEA or JFS and the provider will cooperate with each other to find mutually agreeable and expeditious ways to address and resolve the client's issue.

   If a case should arise in which CCHEA or JFS and the provider are unable to reach a mutually agreeable resolution to the grievance within the required timeframe as stated below, CCHEA or JFS shall make a finding based on the facts as they are known. The grievance disposition letter shall include this finding. The letter may include a request that the provider write a Plan of Correction to be submitted by the provider directly to the MHP Director or designee. CCHEA or JFS may also choose to include what they believe to be equitable, enforceable suggestions or recommendations to the provider for resolution of the matter. Notification of the resolution shall go out to all parties as described below.

8. CCHEA or Patient Advocacy Program shall notify the client in writing regarding the disposition of the grievance within the timeframe for resolution stated below. The notice shall include:
   - the date
   - the resolution

   A copy of the grievance resolution letter will be sent to the provider and the QM Unit at the time the letter is sent to the client.

9. Timelines for grievance dispositions cannot exceed 90 calendar days from the date of receipt of the grievance. However, in some limited instances, it may be necessary for the timeframe to be extended by up to 14 calendar days for good cause, such as a satisfactory resolution is pending but not complete. Timeliness of grievance resolution is an important issue for consumers. If an extension is required, CCHEA or JFS will contact the client to discuss an extension, clearly document in the file the extenuating circumstances that indicate the need for the extension, and the date the client was contacted and agreed to an extension. If the timeframe extension was not requested by the client, CCHEA or JFS staff must give the client written notice of the reason for the delay. If CCHEA or JFS staff is

unable to meet the timeframe described herein, the staff person shall issue a Notice of Adverse Benefit Determination for Timely Access (NOABD-Timely Access) to the beneficiary informing them of their rights. A copy of the NOABD shall be sent to the QM Unit. Clients whose grievances are not completed according to mandated timelines, and have not given permission for an extension, may request a State Fair Hearing. They need not wait until the end of the County process to make this request.

10. CCHEA or JFS Patient Advocacy Program shall record in the log, the final disposition of the grievance, and date the decision was sent to the client, or reason there has not been a final disposition of the grievance.

11. Providers who do not successfully resolve the grievance with the advocacy organization during the grievance process shall receive two letters from CCHEA or JFS. One is a copy of the disposition sent to the client, that includes a request for Plan of Correction, and the other is a letter requesting that the provider write a Plan of Correction and submit it within 10 working days directly to:

Grievance Plan of Correction
Quality Management Unit
P.O. Box 85524, Mail Stop P531G
Camino Del Rio South
San Diego, CA 92186-5524

The Plan of Correction letter to the provider (not the grievance disposition letter) may include CCHEA's or JFS's suggestions of what the Plan of Correction could include. Responsibility for reviewing the Plan of Correction and monitoring its implementation rests with the MHP. The monitoring of any provider's Plan of Correction and handling of any provider's request for administrative review shall be performed by the MHP directly with the provider.

In the event that a provider disagrees with the findings of the grievance investigation as decided by the advocacy organization and does not agree to write a Plan of Correction, the provider may choose instead to write a request for administrative review by the MHP. This request shall be submitted directly by the provider to the MHP Director or designee within 10 business days of receipt of the grievance disposition. The provider must include rationale and evidence to support the provider's position that the disposition of the grievance is faulty and/or that no Plan of Correction is indicated.

Reminder: Providers shall not subject a client to any discrimination or any other penalty of any kind for filing a grievance.

GRIEVANCE PROCESS

STEP	ACTION	TIMELINE
1	Grievance Filed by client	Filing Date
2	Grievance Logged	1 Business Day from Grievance Filing
3	Written Acknowledgement to client	5 Calendar Days from Grievance Filing
4	Provider Contact	Within 2 Business Days from Client's Written Permission to Represent
5	Clinical Consultant review, if applicable	Within 90 day total timeframe
6	Grievance Disposition	90 Days from Filing Date
7	Disposition Extension (if needed)	14 Calendar Days from the 90th day
8	Provider Plan of Correction (if needed)	10 Business Days from Disposition Date
9	Request for Administrative Review	10 Business Days from receipt of the Grievance Disposition

V. APPEAL PROCESS—available to Medi-Cal Beneficiaries only

The appeal procedure begins when a Medi-Cal beneficiary contacts JFS Patient Advocacy Program (for issues relating to inpatient and other 24-hour care program) or CCHEA (for issues relating to outpatient, day treatment and all other services) to file an appeal to review an "action."

An "action" is defined by 42 Code of Federal Regulations as occurring when the MHP does at least one of the following:

- Denies or limits authorization of a requested service, including the type or level of service;
- Reduces, suspends, or terminates a previously authorized service;
- Denies, in whole or in part, payment for a service;
- Delays completion of the MHP appeals process within the mandated timeframe, without client permission for an extension.

In San Diego County this is relevant only for inpatient, day treatment, and outpatient services provided by fee-for-service providers, as these are currently the only services for which an authorization is required. Clients wishing to have a review of a clinical decision made by an individual provider, not the MHP or its administrative services organization, may use the grievance process.

The MHP is required to provide *Aid Paid Pending* for beneficiaries who want continued services, and have made a timely request for an appeal:

- within 10 days of the date the NOABD was mailed, or
- within 10 days of the date the NOABD was personally given to the beneficiary, or
- before the effective date of the service change, whichever is later.

The MHP must ensure that benefits are continued while the appeal is pending, if the beneficiary

so requests. The beneficiary must have:

- an existing service authorization which has not lapsed, and the service is being terminated, reduced, or denied for renewal by the MHP, or
- been receiving specialty mental health services under an 'exempt pattern of care' (see Section X. Definitions).

The benefits will stay the same until the period covered by the existing authorization expires, the date an appeal is resolved, or a hearing decision is rendered, or the date on which the appeal or state fair hearing is otherwise withdrawn or closed, whichever is earliest.

Federal regulations require beneficiaries to file an appeal within 60 calendar days from the date on the NOABD. The MHP shall adopt the 60-calendar day timeframe in accordance with the federal regulations. Beneficiaries must also exhaust the Plan's appeal process prior to requesting a State hearing. A beneficiary, or provider and/or authorized representative, may request an appeal either orally or in writing. Appeals filed by the provider on behalf of the beneficiary require written consent from the beneficiary.

VI. APPEAL PROCEDURES

1. The client may file the appeal orally or in writing. If the appeal is oral, the client is required to follow up with a signed, written appeal. The client shall be provided with assistance in completing the written appeal, if requested. The date of the oral appeal begins the appeal resolution timeframe, regardless of when the follow-up, written appeal was signed. The client may present evidence in person or in writing.

2. CCHEA or JFS Patient Advocacy Program, as appropriate, determines whether the appeal meets the criteria for expedited appeal and, if so, follows the expedited appeal process as stated in section VI below.

3. CCHEA or Patient Advocacy Program logs the appeal within one business day of receipt. The log shall include the:
   - client name or other identifier,
   - date the appeal was received,
   - date the appeal was logged,
   - nature of the appeal,
   - the provider involved,
   - and whether the issue concerns a child.

   The log is to be maintained in a confidential location at CCHEA or JFS Patient Advocacy. If the client requests to see the log, CCHEA or JFS will summarize in writing the content pertaining to the client.

4. CCHEA or JFS shall acknowledge, in writing, receipt of the appeal within five calendar days.
5. CCHEA or JFS shall contact the provider within two business days of receipt of the client's written authorization to represent the client.
6. CCHEA or JFS Patient Advocacy Program shall notify the QM Unit within three business days of any appeal filed.
7. CCHEA or JFS evaluates the appeal and:

- Ensures that the person who determines the final resolution of the appeal has had no decision-making involvement in any prior level of review.
- Safeguards the client's confidentiality per all applicable laws.

  In cases where the CCHEA or JFS staff member has another existing relationship with the client or provider, that contractor's Program Director shall reassign the case or consult with the MHP QM Unit about conflict of interest of issues.

8. If the appeal is about a clinical issue, the decision-maker must also be a mental health professional with the appropriate clinical expertise in treating the client's condition.

9. All County-operated programs and contracted providers are required by contract to cooperate with the problem resolution process as it is described herein. The full participation and timely cooperation of the provider are essential in honoring the client's right to an efficient, effective problem resolution process. During the resolution of the client's appeal, CCHEA or JFS staff will often find it necessary to discuss the issue with the providers involved and the Administrative Service Organization (ASO), either in person or by phone at various points in the process. The expectation is that CCHEA or JFS, the ASO, and the provider will cooperate with each other to find mutually agreeable and expeditious ways to address and resolve the client's issue.

   If CCHEA or JFS denies the appeal, or if the appeal is granted but is not an appeal of one of the actions listed in Item #10 below, proceed to item #12.

10. If CCHEA or JFS believes that there is sufficient merit to grant an appeal regarding an action that:

    - denied or limited authorization of a requested service, including the type or level of service,
    - reduced, suspended or terminated a previously authorized service, or
    - denied, in whole or in part, payment for a service, CCHEA or JFS shall do the following within 20 calendar days of the date the appeal was filed:

      a) notify the MHP Director or designee in writing of details of the appeal and the specific, supported rationale for why it should be granted, and
      b) provide copies to the MHP Director or designee of all relevant medical records, the clinical consultant's evaluation, case notes, and other materials including an accurate representation of the provider's position regarding the appeal.

         In some limited instances, it may be necessary for the timeframe to be extended by up to 14 calendar days for good cause, such as a satisfactory resolution is pending but not complete.

11. The MHP Director or designee shall return a decision on the appeal to the advocacy organization within 10 calendar days of receipt of the above.

12. CCHEA or JFS shall notify the beneficiary in writing regarding the disposition of the appeal within the timeframe for resolution stated below. The notice shall include:

- the date,
- the resolution,
- and if the decision is not wholly in favor of the client AND the client is a Medi-Cal beneficiary, information regarding:
- the right to request a State Fair Hearing within 90 days of notice of the decision,
- how to request a State Fair Hearing, and
- the beneficiary's right to request services while the hearing is pending and how to make that request for continued services.
- A copy of the appeal resolution letter will be sent to the provider and the Quality Management (QM) Unit at the time the letter is sent to the client.

13. Appeals must be resolved within 30 calendar days (44 calendar days if extension granted) from the date of receipt of the appeal. Timeliness of appeal resolution is an important issue for consumers. If an extension is required, CCHEA or Patient Advocacy Program will contact the client to discuss an extension, document clearly in the file the extenuating circumstances for the extension, and the date the client was contacted and agreed to an extension.
14. If the timeframe extension was not requested by the client, CCHEA or Patient Advocacy staff must give the client written notice of the reason for the delay. The notice shall include the client's right to file a grievance if the client disagrees with the decision to extend the timeframe.
15. If CCHEA or Patient Advocacy staff is unable to meet the timeframe described herein, they are required to issue an NOABD-Timely Access to Medi-Cal beneficiaries only. A copy shall be sent to the QM Unit. CCHEA or JFS Patient Advocacy Program shall record in the log the final disposition of the appeal, and the date the decision was sent to the client, or the reason for no final disposition of the appeal.
16. If the decision of the appeal process reverses a decision to deny services, those services shall be promptly provided.

    Reminder: Providers shall not subject a client to any discrimination or any other penalty of any kind for filing an appeal.

APPEALS PROCESS

STEP	ACTION	TIMELINE
1	Appeal Filed by client	File Date
2	Appeal Logged	1 Business Day from Appeal
3	Expedited Appeal Criteria?	Go to Section VII
4	Written Acknowledgement of appeal to client	5 Calendar Days from Receipt of Appeal
5	Provider Contact	2 Business Days from Client's Written Permission to Represent
6	Clinical consultant review, if applicable	As soon as possible
7	Notify QM Unit	3 Business Days of Appeal Filing
8	Advocacy Organization recommends denying appeal	See #10 for timelines

9	Advocacy Organization recommends granting the appeal, and notifies MHP Director in writing with supporting documentation	Within 20 calendar days from date appeal was filed
10	MHP Director makes decision on the appeal	Within 10 calendar days from receipt of appeal.
11	**Appeal Resolution**	**30 Calendar Days from Receipt of Appeal**
12	Appeal Extension (if needed)	14 Calendar Days from Extension Filing Date

VIII. EXPEDITED APPEAL PROCESS—available to Medi-Cal beneficiaries only

When a client files an oral or written appeal to review an action (as previously defined) and use of the standard appeal resolution process could, in the opinion of the client, the MHP, or CCHEA or JFS Patient Advocacy program staff, jeopardize the client's life, health or ability to attain, maintain, or regain maximum function, the expedited appeal process will be implemented instead.

IX. EXPEDITED APPEAL PROCEDURES

1. The client may file the expedited appeal orally or in writing.
2. The CCHEA or Patient Advocacy Program logs the expedited appeal within one working day of receipt. The log shall include the:

   - client name or other identifier,
   - date appeal was received,
   - date the appeal was logged,
   - nature of the appeal,
   - provider involved,
   - and whether the issue concerns a child.

3. The log is to be maintained in a confidential location at CCHEA or JFS Patient Advocacy. If the client requests to see the log, the advocacy agency will summarize in writing the content pertaining to the client.
4. CCHEA or Patient Advocacy Program provides the client a written acknowledgement of receipt of the expedited appeal within two working days.
5. CCHEA or Patient Advocacy Program shall notify the QM Unit immediately of any expedited appeal filed. CCHEA or Patient Advocacy Program shall contact the provider as soon as possible but not to exceed two business days.
6. The client or his or her representative may present evidence in person or in writing.
7. CCHEA or Patient Advocacy Program evaluates the expedited appeal.
   - They shall ensure that the person who determines the final resolution of the appeal has had no decision-making involvement in any prior level of review.
   - The client's confidentiality shall be safeguarded per all applicable laws.

8. If the expedited appeal is about a clinical issue, the decision-maker must also be a mental health professional with the appropriate clinical expertise in treating the client's condition.

9. If, in the opinion of CCHEA or Patient Advocacy Program, the appeal does not meet the criteria for the expedited appeal process that has been requested, CCHEA or Patient Advocacy program staff shall:
   - Obtain agreement of the MHP to deny the use of the expedited appeal process and to treat the appeal as a standard appeal instead.
   - Transfer the appeal to the timeframe for standard appeal resolution (above), and
   - Make reasonable efforts to give the client prompt oral notice of the denial of the expedited process and follow up within two calendar days with a written notice. A copy of the letter shall be sent to QM.

10.. All County-operated programs and contracted providers are required by contract to cooperate with the problem resolution process as it is described herein. The full participation and timely cooperation of the provider are essential to honoring the client's right to an efficient, effective problem resolution process. During the resolution of the client's expedited appeal, CCHEA or JFS staff will often find it necessary to discuss the issue with the providers involved, and the Administrative Service Organization (ASO), either in person or by phone at various points in the process. The expectation is that CCHEA or JFS, the ASO, and the provider will cooperate with each other to find mutually agreeable and expeditious ways to address and resolve the client's issue.

If CCHEA or JFS denies the expedited appeal, or if the expedited appeal is granted but is not an appeal of one of the actions listed in item #12 below, *proceed to item #14.*

11. If the advocacy organization believes that there is sufficient merit to grant an expedited appeal regarding an action that:
   - denied or limited authorization of a requested service, including the type or level of service,
   - reduced, suspended or terminated a previously authorized service, or
   - denied, in whole or in part, payment for a service, the advocacy organization shall do the following within two business days of the date the appeal was filed:
     - notify the MHP Director or designee in writing of details of the expedited appeal and the specific, supported rationale for why it should be granted, and
     - provide copies to the MHP Director or designee of all relevant medical records, the clinical consultant's evaluation, case notes, and other materials including an accurate representation of the provider's position regarding the expedited appeal.

12. The MHP Director or designee shall return a decision on the expedited appeal to the advocacy organization within one business day of receipt of the above.

13. CCHEA or Patient Advocacy Program shall make a reasonable effort to notify the client orally of the expedited appeal resolution decision as soon as possible. In addition, they shall notify the client in writing within the timeframe for resolution stated below, regarding the results of the expedited appeal. The notice shall include:
   - the date,
   - the resolution,
   - and only if the decision is not wholly in favor of the client AND the client is a Medi-Cal beneficiary
   - information regarding the right to request an expedited State Fair Hearing

- information on how to request continued services (aid paid pending) while the hearing is pending.
- A copy of the appeal resolution letter will be sent to the provider and the QM Unit at the same time the letter is sent to the client.

14. Expedited appeals must be resolved, and the client must be notified in writing within three business days from the date of receipt of the expedited appeal. However, in some limited instances, it may be necessary for the timeframe to be extended by up to 14 calendar days if the client requests an extension. In rare circumstances, the timeframe may be extended up to the 14 calendar days if CCHEA or JFS staff determines that there is a need for more information AND that the delay is in the client's best interest.

15. If the timeframe extension was not requested by the client, CCHEA or JFS Patient Advocacy staff must give the client written notice of the reason for the delay.

16. If CCHEA or JFS staff is unable to meet the timeframe described herein, they shall issue an NOABD-Timely Access to the beneficiary. A copy shall be sent to the QM Unit.

17. CCHEA or JFS Patient Advocacy Program shall record in the log the final disposition of the expedited appeal, and the date the decision was sent to the client, or reason there has not been a final disposition of the expedited appeal.

18. If the decision of the appeal process reverses a decision to deny services, those services shall be promptly provided.

Reminder: Providers shall not subject a client to any discrimination or any other penalty of any kind for filing an appeal.

STEP	ACTION	TIMELINE
1	Expedited Appeal Filed by client	File Date
2	Expedited Appeal Criteria? If not, obtain MHP agreement and treat as regular appeal.	If no, notify client in 2 calendar days in writing
3	Expedited Appeal Logged	1 Business Day from Appeal receipt
4	Written Acknowledgement of appeal to client	2 Business Days from Receipt of Appeal
5	Provider Contact	2 Business Days from Client's Written Permission to Represent
6	Notify QM Unit	Immediately
7	Advocacy Organization recommends denying appeal	See #10 above for timelines
8	Advocacy Organization recommends granting the appeal, and notifies MHP Director in writing with supporting documentation.	Within 2 Business days from date appeal was filed
9	MHP Director makes decision on the appeal	Within 1 Business day from receipt of notification from the Advocacy Organization

10	Appeal Resolution	3 Business Days from Receipt of Appeal
11	Disposition Extension (if needed)	14 Calendar Days from 3rd Business day.

X. STATE FAIR HEARING—available to Medi-Cal beneficiaries only, who are not receiving services through the Department of Education

A. A State Fair Hearing is a legal process that includes an impartial hearing and ruling by an administrative law judge. A Medi-Cal beneficiary is required to exhaust the MHP's problem resolution process above prior to requesting a State Fair Hearing. Only a Medi-Cal beneficiary may request a state hearing:

- within 90 days after the completion of the MHP beneficiary problem resolution process, whether or not the client received a Notice of Adverse Benefit Determination (NOABD), or
- when the grievance or appeal has not been resolved within mandated timelines, and who gave no permission for an extension. The beneficiary does not need to wait for the end of the MHP Problem Resolution process.

A Medi-Cal beneficiary may request a State Fair Hearing by writing to or calling the State Fair Hearings Division of the California Department of Social Services at 1(800) 952-5253, or by contacting CCHEA or JFS Patient Advocacy Program for assistance.

Children and youth receiving mental health services under AB 3632/2726 legislation through the Department of Education should use that Department's Grievance and Appeals process.

B. When the MHP QM Unit has been notified by the State Fair Hearings Division that an appeal or state fair hearing has been scheduled, the QM Unit shall:

1. Contact the client or his or her advocate, investigate the problem, and try to resolve the issue before the matter goes to State Fair Hearing. In cases where a successful resolution of the matter is not reached, the client proceeds to a hearing.
2. Attend the hearing to represent the MHP position.
3. Require that County-operated and/or contracted providers involved in the matter assist in the preparation of a position paper for the hearing, and/or may be requested to attend the hearing as a witness in the case.
4. The MHP is required to provide *Aid Paid Pending* for beneficiaries who want continued services while awaiting a Hearing, have met the Aid Paid Pending criteria per CCR, Title 22, Section 51014.2 summarized below, and have made a timely request for a fair hearing:
    - within 10 days of the date the NOABD was mailed, or
    - within 10 days of the date the NOABD was personally given to the beneficiary, or
    - before the effective date of the service change, whichever is later.
5. The beneficiary must have:

- an existing service authorization which has not lapsed and the service is being terminated, reduced, or denied for renewal by the MHP, or
- been receiving specialty mental health services under an 'exempt pattern of care' (see Section XII. Definitions).

6. The benefits will stay the same until the period covered by the existing authorization expires, the date an appeal is resolved or a hearing decision is rendered, or the date on which the appeal or state fair hearing is otherwise withdrawn or closed, whichever is earliest.

7. After a judge has heard a case, he or she forwards the decision to the MHP QM Unit. In the event that the case is not resolved in the MHP's favor, the QM Unit staff shall communicate the decision and any actions to be implemented, to the MHP Program Monitors to oversee implementation of the resolution by the County- operated and/or contracted providers.

Please note: A beneficiary may file an appeal or state fair hearing whether or not a Notice of Adverse Benefit Determination (NOABD) has been issued.

XI. MONITORING GRIEVANCES AND APPEALS

The MHP QI Unit shall be responsible for monitoring grievances and appeals, identifying issues and making recommendations for needed system improvement.

A. Procedures

1. The MHP QM Unit shall review the files of CCHEA and JFS Patient Advocacy program periodically and as frequently as needed in order to monitor timely adherence to the policy and procedures outlined herein and ensure that consumer rights under this process are protected to the fullest extent.

2. On a monthly basis, by the 20th of the following month, JFS Patient Advocacy Program and CCHEA shall submit their logs of all grievances and appeals for the previous calendar month, to the MHP QM Unit. The logs shall specify whether each item is a grievance, appeal, or expedited appeal. They shall include the:

   - client name or other identifier
   - date the grievance or appeal was filed,
   - date logged
   - nature of the grievance or appeal
   - provider involved,
   - and whether the issue concerns a child.

3. For those grievances and appeals that have been resolved, the log shall note the final disposition of the grievance or appeal, and the date the decision was sent to the client.

4. The MHP QM Unit will keep centralized records of monitoring grievances and appeals, including the nature of the grievance/appeal, as well as track outcomes

of appeals that were referred to other entities including State Fair Hearings. Trends will be identified and referred to the Quality Review Council, MHP Director, and/or Mental Health Board for recommendations or action as needed. The MHP QM Unit shall submit a grievance and appeal log to the State Department of Mental Health annually.

B. Handling Complaint Clusters

1. CCCHEA and JFS Patient Advocacy shall report to the QM Unit complaint clusters about any one provider or therapist occurring in a period of several weeks or months, immediately upon discovery. Background information and copies of client documentation shall be provided to the QM Unit also.

2. The QM Unit will investigate all such complaint clusters.

3. Findings will be reported to the MHP Director.

XII. DEFINITIONS

ASO: Administrative Service Organization contracted by HHSA to provide Managed Care Administrative functions.

Action: As defined by 42 Code of Federal Regulations (CFR) an action occurs when the Mental Health Plan (MHP) does at least one of the following:

- Denies or limits authorization of a requested service, including the type or level of service;
- Reduces, suspends, or terminates a previously authorized service;
- Denies, in whole or in part, payment for a service;
- Fails to provide services in a timely manner, as determined by the MHP or;
- Fails to act within the timeframes for disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals.

Appeal: A request for review of an action (as action is defined above).

Beneficiary: A client who is Medi-Cal eligible and currently requesting or receiving specialty mental health services paid for under the County's Medi-Cal Managed Care Plan.

Client: Any individual currently receiving mental health services from the County MHS system, regardless of funding source.

Consumer Center for Health Education and Advocacy (CCHEA):	CCHEA is an MHP contractor currently designated by the Local Mental Health Director to fulfill two roles: to operate the County's Grievance and Appeal process for client problems with outpatient and all other non-residential mental health services; and to provide patient advocacy services which include information and education on client rights and individual assistance for mental health clients with problems accessing/maintaining services in the community.
Consumer:	Any individual who is currently requesting or receiving specialty mental health services, regardless of the individual's funding source and/or has received such services in the past and/or the persons authorized to act on his/her behalf. (This includes family members and any other person(s) designated by the client as his/her support system.)
Grievance:	An expression of dissatisfaction about any matter other than an action (as action is defined).

Grievance and Appeal Process:	A process for the purpose of attempting to resolve consumer problems regarding specialty mental health services.
Mental Health Plan (MHP):	County of San Diego, Health & Human Services Agency, Mental Health Services.
Notice of Adverse Benefit Determination (NOABD):	A notice sent to Medi-Cal beneficiaries to inform them of a decision regarding denial, reduction, or termination of requested services and their rights for appeal if they disagree with the decision. NOABD-Denial of Authorization Notice: The MHP denies a request for service. Denials include determinations based on type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit. This notice used for denied residential services. . NOABD- Delivery System Notice: The MHP determined that the beneficiary does not meet the criteria to be eligible for specialty mental health services through the MHP. The beneficiary will be referred to the Managed Care Plan, or other appropriate system, for mental health or other services. NOABD- Modification Notice: The MHP modifies or limits a provider's request for a service , including reductions in frequency and/or duration of services, and approval of alternative treatments and services. NOABD- Termination Notice: The MHP terminates, reduces, or suspends a previously authorized service. NOABD- Timely Access Notice: When there is a delay in providing the beneficiary with timely services, as required by the timely access standards applicable to the delayed service. NOABD- Authorization Delay Notice: When there is a delay in processing a provider's request for authorization of specialty mental health services or substance use disorder residential services. When the MHP extends the timeframes to make an authorization decision, it is a delay in processing a provider's request. This includes extensions granted when there is a need for additional information from the beneficiary or provide, when the extension is in the beneficiary's interest. NOABD- Financial Liability Notice: The MHP denies a beneficiary's request to dispute financial liability, including cost-sharing and other beneficiary financial liabilities. NOABD- Payment Denial Notice: The MHP denies, in whole or in part, for any reason, a provider's request for payment for a service that has already been delivered to a beneficiary.

Patients' Rights Advocate: The persons designated under Welfare and Institutions Code, Section 5500 et seq. to protect the rights of all recipients of specialty mental health services. The Patients' Rights Advocate "shall have no direct or indirect clinical or administrative responsibility for any recipient of Medi-Cal Managed Care Services and shall have no other responsibilities that would otherwise compromise his or her ability to advocate on behalf of specialty mental health beneficiaries."

JFS Patient Advocacy Program staff currently serves as the Patients' Rights Advocate for acute inpatient and other 24-hour residential services, and CCHEA staff serves as the Patients' Rights Advocate for outpatient, day treatment, and all other services.

Quality Management (QM) Program: The Quality Management Program is a unit within HHSA Behavioral Health Services whose duties include monitoring and oversight of the Grievance and Appeal Process.

State Fair Hearing: A formal hearing before an administrative law judge, requested by a Medi-Cal beneficiary and conducted by the State Department of Social Services as described in Welfare and Institutions Code, Section 10950, and Federal Regulations Subpart E, Section 431.200 et seq.

Jewish Family Service (JFS) Patient Advocacy Program: The Jewish Family Service Patient Advocacy Program is an agency currently designated by the Local Mental Health Director to fulfill two roles: to operate the County's Grievance and Appeal process for client problems in acute care hospitals and residential services; and to provide patient advocacy services which include information and education on patient rights and individual client assistance in resolving problems with possible violations of patient's rights.

Appendix J
SERIOUS INCIDENT REPORTING

SERIOUS INCIDENT REPORTING

An incident that may indicate potential risk/exposure for the County – operated or contracted provider (per Statement of Work), client or community shall be reported to the BHS Quality Management Unit. There are two types of reportable incidents, 1) Serious Incidents are reported to the BHS QM Unit and 2) Unusual Occurrences are reported directly to the program's Contracting Officer's l Representative (COR).

All providers are required to report serious incidents involving clients in active treatment or whose discharge from services has been 30 days or less. Required reports shall be sent to the QM Unit who will review, investigate as necessary, and monitor trends. The QM team will communicate with program's COR and BHS management. The provider shall also be responsible for reporting serious incidents to the appropriate authorities.

Serious Incident Categories: Level One and Level Two

Serious incidents shall be classified into two levels with Level One being most severe and Level Two less severe.

A Level One incident must include at least one of the following:

- The event has the potential for significant adverse media involvement, i.e. appears on local news station, in the newspaper, internet website, reported in the public domain.
- The event is associated with a significant adverse deviation from the usual process for providing behavioral health care.
- The event has results in a death or serious physical injury on the program's premises.

For **Level One**, upon knowledge of the incident, the provider shall immediately verbally report the incident to the QM SIR Line at 619-584-3022. The provider shall complete a Serious Incident Report and fax it to the QM Unit within 24 hours of knowledge of incident.

For **Level Two**, upon knowledge of the incident, the provider shall verbally report the incident to the QM SIR at 619-584-3022. The provider shall complete a Serious Incident Report and fax it to the QM Unit within 72 hours of knowledge of incident. A level two incident is any serious incident that does not meet the criteria of a Level One serious incident.

Serious incidents are categorized as follows:

- Incident reported in the media/public domain (e.g. on television, newspaper, internet)
- Death of client by suicide (includes overdose by alcohol/drugs/medications, etc.)
- Death of client under questionable circumstances (includes overdose by alcohol/drugs/medications, etc.)
- Death of client by homicide
- Suicide attempt by client that requires medical attention or attempt is potentially fatal and/or significantly injurious.
- Alleged homicide committed by a client (client is perpetrator)
- Alleged homicide attempt by a client (client is perpetrator)
- Alleged homicide attempt on a client (client is victim)
- Injurious assault on a client (client is victim) occurring on the program's premises resulting in severe physical damage and/or loss of consciousness, respiratory and/or circulatory difficulties requiring hospitalization.

- Injurious assault by a client (client is perpetrator) occurring on the program's premises resulting in severe physical damage and/or loss of consciousness, respiratory and/or circulatory difficulties requiring hospitalization.
- Tarasoff Notification, the duty to protect intended victim, is made to the appropriate person(s), police, or other reasonable steps have been taken to protect the intended victim.
- Tarasoff Notification, the duty to protect intended victim, is received by the Program that a credible threat of harm has been made against a staff member(s) or Program and appropriate safety measures have been implemented.
- Serious allegations of or confirmed inappropriate staff (includes volunteers, interns) behavior such as sexual relations with a client, client/staff boundary issues, financial exploitation of a client, and/or physical or verbal abuse of a client.
- Serious physical injury resulting in a client experiencing severe physical damage and/or loss of consciousness; respiratory and/or circulatory difficulties requiring hospitalization.
- Adverse medication reaction resulting in severe physical damage and/or loss of consciousness; respiratory and/or circulatory difficulties requiring hospitalization.
- Medication error in prescription or distribution resulting in severe physical damage and/or loss of consciousness; respiratory and/or circulatory difficulties requiring hospitalization.
- Apparent overdose of alcohol/illicit or prescriptions drugs, whether fatal or injurious, requiring medical attention.
- Major confidentiality breach (lost or stolen laptop, client files/records accessed, PHI breach, etc.)
- Use of physical restraints (prone or supine) only during program operating hours (applies only to CYFmental health clients during program operating hours and excludes ADS programs, Hospitals, Long-Term Care Facilities, San Diego County Psychiatric Hospital/EPU, ESU and PERT)
- Other

Serious Incident Reporting Procedures

1. Upon knowledge of incident, program shall verbally report the incident and all known details to the SIR Line at 619-584-3022.
2. All providers are required to report serious incidents involving clients in active treatment or whose discharge from services has been 30 days or less.
3. A Level One serious incident shall be verbally report to the SIR Line immediately upon knowledge of the incident and followed up with the written SIR report to QM no later than 24 hours.
4. A Level Two serious incident shall be verbally reported to the SIR Line no later than 24 hours of knowledge of the incident and followed up with the written SIR report to QM within 72 hours.
5. All program staff will maintain confidentiality about client and serious incident. The serious incident should not be the subject of casual conversation among staff.
6. All serious incidents shall be investigated and reviewed, and the Report of Findings form shall be completed and faxed to QM within 30 days of knowledge of incident.
7. An SIR is not part of the client medical record and should never be filed in the medical record. A Serious Incident Report should be kept in a separate, confidential file.

LINK:

The following documents can be found on the Optum website:

A – Serious Incident Report (SIR)

B – Serious Incident Report Findings (SIRF)

https://www.optumsandiego.com/content/sandiego/en/county-staff---providers/fee-for-service-providers.html

CONFIDENTIAL
SERIOUS INCIDENT REPORT (SIR)

County of San Diego Behavioral Health Services (BHS)
QM CONFIDENTIAL FAX: 619-236-1953 Serious Incident Report Line 619-584-3022
Fax LEVEL ONE SIR within 24 hours. Fax Level Two SIR within 72 hours.

SIR INSTRUCTIONS

LEVEL ONE incident shall be reported to the BHS Serious Incident Report Line **immediately**.

NOTE: Reporting of a serious incident is based on criteria and determined severity of the serious incident.

A **LEVEL ONE** Serious Incident is the most severe type of incident. A level one incident must include at least one of the following:

- Any event that has been reported in the media current or recent past regardless of type of incident.
- The event has resulted in a death or serious physical injury **on the program's premises**.
- The event is associated with a significant adverse deviation from the usual process for providing behavioral health care.

A level one serious incident must be reported to Quality Management (QM) immediately upon knowledge of the incident. Call 619-584-3022.

A **LEVEL ONE** Serious Incident that occurs on the weekend or holiday shall be reported in accordance with the procedure documented in the Organizational Provider Operations Handbook (OPOH) and the Substance Use Disorder Provider Operations Handbook (SUDPOH).

All other serious incidents are reported as Level Two incidents. For consultation, call QM Program Manager.

Privacy Incident Reporting (PIR): Report only to HHSA Compliance Office via online portal.

Report of Findings shall include a **thorough review** of the serious incident, relevant findings and quality improvement activities. The Report of Findings shall be submitted within 30 days of the reported serious incident. If a RCA was completed, then complete the TCA section only.

A **Root Cause Analysis (RCA)** is required for any serious incident that results in 1) a completed suicide, 2) a privacy incident 3) alleged homicide committed by client 4) as requested by QM. The RCA and RCA Report of Findings shall be completed and submitted to QM within 30 days of the reported serious incident.

NOTE: The SIR form must be typed. Handwritten reports will be returned to programs for a typed report.

ALL FIELDS ARE REQUIRED AND MUST BE COMPLETED UNLESS OTHERWISE NOTED.
INCOMPLETE FORMS MAY BE RETURNED.

If you have questions about any serious incident, please contact the QM Program Manager at 619-584-3081.

Questions? Call for consultation.

Appendix K
DENIAL OF RIGHTS/SECLUSION AND RESTRAINT MONTHLY REPORT – DHCS 1804

INSTRUCTIONS FOR DHCS 1804

COLUMN A: Patient's I.D. or Hospital Number

Each patient who has been denied a right or placed in seclusion/restrain by the facility during the reporting month must be listed on this form by 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 Right or Days in Seclusion/Restraint

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

ROW D: Totals – Number of Patients Denied Each Right

Enter in Row D, 1 through 10, the total number of patients denied each right or placed in seclusion/restraints.

(Do not count the numbers in the boxes to achieve Row 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 patients' rights, such as the right of access to the telephone.

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

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

SUBMIT TO: The Quality Improvement Unit, County of San Diego Mental Health Services by the 10th of the month following the end of the quarter. An aggregated report will be submitted by the local Mental Health Director to appropriate State offices.

DENIAL OF RIGHTS/SECLUSION AND RESTRAINT MONTHLY REPORT

DHCS 1804 (06/2013)

Month:

Year:

Facility:

Program/Ward:

County:

Name, Title & Telephone No. of Person Preparing Report:

Date of Report:

A. Patient's I.D.	B. NO. of Days in Facility	C. Number of Days Denied Each Right or Days in Seclusion/Restraint									
		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 clothes 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 WIC5325(a)
4. Right to have access to individual storage space for one's private use WIC 5325(b)
5. Right to see visitors each day WIC 5325(c)
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 material, including stamps WIC 5325(e)
8. Right to mail and receive unopened correspondence WIC 5325(e)

RESTRICTIONS IMPOSED: (See Reverse Side)

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

Appendix L
QUARTERLY REPORT ON INVOLUNTARY DETENTIONS

QUARTERLY REPORT ON INVOLUNTARY DETENTIONS

Instructions – DHCS 1805

The Monthly Facility Report, Form DHCS 1804 is completed by each facility and sent to the County designee assigned the task of completing the County Summary, Form DHCS 1805. Most of the data to be entered on form DHCS 1805 is obtained from form DHCS 1804.)

County: Enter the full name of your county here.
Date of Report – Enter the date the report is being completed.
Month/Year – Month and Year that data on this report represents.
Name/Title/Phone/ of Person Preparing Report – county designee

List of Facilities - In Section (A) enter the name of all the facilities that have provided a DHCS 1804. Use the name from the DHCS 1804 "Facility Name".

Type of Facility - In Section (B) enter the facility license type for each facility listed in Section (A) of 1805 . If the facility types listed below do not match the facility in Section (A) refer to HS1250.1 for additional facility types.

Department of Mental Health (DMH) **January 2008**	***Department of Social Services***	***Department of Public Health CDPH)***
MHRC = Mental Health Rehabilitation Center **PHF** = Psychiatric Health Facility *CSU = Crisis Stabilization Unit (23-hour bed)*	*CTF = Community Treatment Facility* *CCF = Community Care Facility* *GROUP HOME*	*PSYCH = Acute Psychiatric Hospital* *SNF/STP = Special Treatment Program* *GACH = General Acute Care Hospital* *ICF (all) = Intermediate Care Facility* *SNF = Skilled Nursing Facility*

(Psych) Bed Capacity - In Section (C) identify the total number of **psychiatric** beds the facility in Section (A) is licensed for (do not use monthly census).

Number of Patients Denied Rights- In Section (D) record the total patient ID numbers from Column (I) of form 1804. If form 1804 requires multiple pages, record the sum of the total line for Column (I). The total number of rights denied may not equal the total number of patient Id's.

Total Number of Days Each Right Denied - On form 1804 Column (V) - each right 1-8 should be totaled at the bottom of the form. Transfer each total to Section (E) of Form 1805. For example, on 1804 Column (V) the total for right 1 should be transferred to Section (E) of Form DHCS 1805. This should be done for each facility listed on DHCS 1805.

Total Rights Denied - On DHCS 1805 count the total numbers of days right 1-8 were denied and enter that total in Section (F) for that facility.

Patient Days - Add total patient days for all units within the same facility from 1804, "Total Patient Days." Enter Patient Days in Section (G) on form DHCS 1805.

Percent Frequency - Divide "Total Days Rights Denied" Section (F) by "Patient Days" Section (G). Do this for each facility listed on form DHCS 1805.

Total Line – On the bottom of form DHCS 1805 there is a total column. Total all columns vertically that have not been grayed.

Forward Completed DHCS 1805 by the 30th of the following month to:

California Office of Patients' Rights
100 Howe Avenue, Suite 210N
Sacramento, CA 95825-8202
(916) 575-1610

Appendix M
CONVULSIVE TREATMENTS ADMINISTERED – QUARTERLY REPORT

CONVULSIVE TREATMENTS ADMINISTERED – QUARTERLY REPORT

County	Reporting Facility or Doctor		Report Date
For Quarter Ending	Number of Patients Treated By Major Source of Payment	Private: _____	3rd Party Payor: _____
		Public: _____	Other: _____

SECTION I — NUMBER OF PATIENTS RECEIVING TREATMENT

PATIENT DISTRIBUTION / PATIENT TYPE	AGE								SEX			RACE							
	12 - 15	16 - 17	18 - 24	25 - 44	45 - 64	65+	Unknown	Totals	Male	Female	Totals	White	Black	Hispanic	Asian	Amer. Indian	Filipino	Other	Totals
Voluntary Patient - With Informed Consent																			
Voluntary Patient - Not capable of Informed Consent																			
Involuntary Patient - With Informed Consent																			
Involuntary Patient - Not Capable of Informed Consent																			
TOTALS																			

SECTION II — TOTAL TREATMENTS GIVEN

Convulsive Treatments																			

SECTION III — COMPLICATIONS ATTRIBUTABLE TO TREATMENT

Cardiac Arrest - Nonfatal																			
Memory Loss - reported																			
Fractures																			
Apnea																			
Death - No Coroner Report																			
Death - With Coroner Report																			
TOTALS																			

SECTION IV — EXCESSIVE TREATMENTS

Patients - Excessive Treatments																			

PREPARED BY:_____

TELEPHONE NUMBER (including area code):_____

SUBMIT TO:
County Mental Health Director

REPORTING INSTRUCTIONS:

1. Complete all heading items

   Note: Under "Number of Patients Treated by Major Source of Payment", enter the number of patients given Convulsive Therapy Treatments according to their Major Source of Payment for Treatment. Categorize Source of Payment into one of the following types: (a) Private, (b) Public (including but not limited to Medicare, Medi-Cal, and Short-Doyle), (c) Third Party Payor, (d) Other (Specify).

2. SECTION I "NUMBER OF PATIENTS RECEIVING TREATMENT"

   A) For each Patient Type (i.e., Voluntary Patient – With Informed Consent, Voluntary Patient – Not Capable of Informed consent, *Involuntary Patient – With Informed consent, and *Involuntary Patient – Not capable of Informed Consent) indicate the number of patients receiving treatment during the report quarter by age group, sex, and race. The PDF form will automatically total the columns and rows. **(If totals do not match, verify data posting.)**

   Involuntary patients include patients under guardianship or conservatorship

3. SECTION II "TOTAL TREATMENTS GIVEN"

   A) Enter the total number of treatments given during the report quarter for all Patient Types by age group, sex, and race. The Excel spread sheet will automatically total the row. **(If totals do not match, verify data posting.)**

4. SECTION III "COMPLICATIONS ATTRIBUTABLE TO TREATMENT"

   A) For each type of complication, enter the number of complications attributable to Convulsive Therapy Treatments that occurred by age group, sex, and race of the patient. The PDF form will automatically total the columns and rows. **(If totals do not match, verify data posting.)**

   B) Complications to be reported:

   a) non-fatal cardiac arrests or arrhythmias which required resuscitative efforts.

   b) memory loss reported by the patient extending more than 3 months following the completion of the course of treatment (when reporting memory loss subsequent to a course of treatment which was reported on a previous quarterly report, designate separately with an asterisk).

   c) fractures, with a medical diagnosis of the fracture accompanying quarterly.

   d) apnea persisting 20 minutes or more after initiation of treatment.

   e) deaths which 1) occur during or within first 24 hours after a treatment; or 2) occur subsequently but are attributable to the treatment. All deaths in the first category shall be reported to the coroner and the coroner's report shall accompany the quarterly report. In all cases in which an autopsy is performed, the autopsy report shall also accompany the quarterly report.

   The required accompanying reports in c) and e) above shall observe the confidentiality requirements of Section 5328 of the Welfare and Institutions Code.

5. SECTION IV "EXCESSIVE TREATMENT"

   A) Indicate the number of patients by age group, sex, and race who receive more than 15 treatments within a 30-day period during the quarter or who received more than 30 treatments within the immediately preceding one year. Attach documentation of the prior approval. The PDF form will automatically total the row. **(If totals do not match, verify data posting.)**

6. **REPORTS must be submitted to the County Mental Health Director as indicated in the lower right corner on the front of this form by the 15th of the month following the completion of the quarter**.

7. **THE COUNTY MENTAL HEALTH DIRECTOR shall transmit the accumulated quarterly reports, by the last day of the month following the end of the quarter, to:**

   Department of Health Care Services
   Mental Health Analytics Section, MS2704
   P.O. Box 997413 Sacramento, CA 95899

NOTE: Section 5326.9 of the welfare and Institutions Code addresses violations of the laws governing the denials of rights.

If you need assistance preparing this report, please send an email to: MHSDATA@dhcs.ca.gov

Appendix N

MENTAL HEALTH WEBSITES

Mental Health Websites

The following websites can be accessed for additional information:

County of San Diego, Health & Human Services Agency:
http://www.sdcounty.ca.gov

State of California Department of Health Care Services:
www.dhcs.ca.gov

Medi-Cal Website:
www.medi-cal.ca.gov

Optum
www.Optumsandiego.com

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

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

National Alliance of Mentally Ill:
www.nami.org

ARC of San Diego
www.arc-sd.com

Appendix O

MEDICAL RECORD CONTENT REQUIREMENT

Medical Record Content Requirements

1. Mental status exam and psychiatric history are documented within 24 hours of admission. The history includes: previous treatment dates, providers, therapeutic interventions and responses, relevant family information, relevant results of lab tests (if applicable) and consultation reports (if applicable).
2. Initial diagnosis meets established medical criteria for acute inpatient admission:
    a. Danger to self, others or property;
    b. Unable to care for self as gravely disabled (other contributing factors need to be handled by appropriate agencies);
    c. Serious adverse reaction to treatment;
    d. Unable to receive care at lower level.
3. Diagnosis is consistent with documented symptoms;
4. Treatment plan is consistent with diagnosis;
5. Therapeutic intervention is consistent with treatment plan;
6. Discharge plan is consistent with treatment plan;
7. Consent for medication treatment form is dated and signed by client;
8. Title 9 covered diagnoses are documented;
9. Documentation of 5150 (including appropriate form) is in chart, if applicable;
10. Documentation of 5270 (including appropriate form) is in chart, if applicable
11. Documentation that the client has signed a Release of Information (ROI) to his/her Primary Physician for the hospital discharge summary;
12. Cultural factors, including client's ethnicity/cultural background and primary language, are documented at admission;
13. If a readmission, how treatment plan addresses contributing problems leading to recurrence.
14. Relevant physical health conditions reported by client are prominently identified and updated as appropriate;
15. Client self-report of allergies and adverse reactions to medications, or lack of known allergies/sensitivities, is clearly documented;
15. Documentation includes past and present use of tobacco, alcohol, and caffeine, as well as illicit, prescribed, and over-the-counter drugs;
16. Transfer to administrative days is documented;
17. Active placement efforts for clients on administrative days are documented;
18. Discharge planning for clients on administrative days is documented;
19. Provision made for translation and/or interpretive services for non-English speaking clients and/or for clients needing sign language assistance is documented;
20. Client's response to offer of an interpreter or sign language assistance is documented;
21. Discharge Title 9 covered diagnoses are documented;
22. Final discharge plan documents referral for outpatient medication management follow-up appointment;
23. Final discharge plan for clients with primary diagnosis of substance abuse/chemical dependency documents recommendations for chemical dependency services;
24. Other community support/agency/outpatient service referrals are documented;
25. Current and recommended living arrangements are documented;
26. Progress notes document reaction to treatment, problems and interventions;
27. Each order and note is signed and dated;
28. Client's referral back to primary care physician is documented;
29. Client's referral back to psychiatrist and/or therapist for outpatient care is documented.

Appendix P

GLOSSARY

Glossary

Beneficiary

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

Consolidation

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 is currently 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 (FFSMC)

California's Medi-Cal program 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 service 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, which 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.

Medi-Cal

California's Medicaid Program.

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 physical 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 less than 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.