D. PROVIDING SPECIALTY MENTAL HEALTH SERVICES

ADULT/OLDER ADULT SYSTEM OF CARE

Coordination of Care: Creating a Seamless System of Care

Coordination of care among inpatient and outpatient service providers is essential for a mental health system to work efficiently. As the client may move between different levels of care, it is vital that service providers communicate with each other to provide continuity of care for the client. This also supports the clients' efforts to return to, achieve and maintain the highest possible level of stability and independence. The MHP Systems of Care stipulates that the provider shall provide each client with a care coordinator as the "single point of accountability" for his or her rehabilitation and recovery planning, and service and resource coordination. The MHP monitors coordination of care.

To this end, the MHP defines a long-term client as any individual that receives behavioral health services beyond 30 days of his/her admission to a behavioral health program. Long-term clients would be expected to have a completed behavioral health assessment and client plan.

72-Hour Post Discharge Coordination of Care

Any new or current client who meets the criteria for needing "urgent" services shall be seen within 72 hours. A need for urgent services is defined in Title 9 as a condition, which without timely intervention, is certain to result in a person being suicidal, homicidal or gravely disabled, and in need of emergency inpatient services. Any person being discharged from a crisis residential facility, a psychiatric hospital, jail, the EPU or a locked/IMD placement that are screened as needing services urgently shall be seen within 72 hours. In addition any other new or current clients who call for services and are screened as needing services urgently also meets the "urgent" criteria and shall be seen within 72 hours. Compliance to this standard is monitored through the Medical Record Review process.

Outpatient Services

The MHP defines adult clients as those between the ages of 18-59 years. Older adults are age 60 and above. Clients may access services through organizational providers and County-operated facilities in the following ways:

- Calling the organizational provider or County-operated program directly
- Walking into an organizational provider or County-operated program directly
- Calling the Access and Crisis Line at 1-888-724-7240

When the provider conducts an assessment of a client who has called or walked into the program, that provider is responsible for entering administrative and clinical information into all the appropriate forms in Cerner Community Behavioral Health (CCBH). Providers must complete the demographic and diagnosis forms and open an Assignment in CCBH. See the Management Information Systems CCBH User Manual, Organizational Provider Operations Handbook, Volume II, for a description of how CCBH supports these provider activities.

If the Access and Crisis Line refers a client to an organizational provider or to a County-operated facility, the ACL opens a record in CCBH for each client. The provider's program staff is then responsible for recording all ongoing activity for that client into CCBH.

Medical Necessity for Outpatient Services

Title 9 (Section 1830.205) Medical Necessity criteria are summarized below. A complete description of Medical Necessity Criteria can be found on the Optum Website.

Services provided to clients by outpatient providers are reimbursed if the following medical necessity criteria are met:

1. The client must have an included Title 9 diagnosis that is reimbursable for outpatient services as described in Title 9, Section 1830.205(1).
2. The client must have at least one of the following as a result of the mental disorder(s):
    - A significant impairment in an important area of life functioning; or
    - A probability of significant deterioration in an important area of life functioning.
3. All of the following:
    - The focus of proposed intervention is to address the significant impairment or probability of significant deterioration in an important area of life functioning;
    - The proposed intervention is expected to benefit the client by significantly diminishing the impairment or preventing significant deterioration in an important area of life functioning; and
    - The condition would not be responsive to physical health care treatment.

SPECIFIC PROCEDURES AND CRITERIA FOR OUTPATIENT CARE

Clarification of Service Mix for Programs

San Diego County Adult/Older Adult Case Management Services are as follows:

- Strengths-Based Case Management (SBCM) programs are only authorized to provide case management brokerage, individual and group rehabilitation, collateral, and occasional crisis intervention services.
    - o Note that the evaluation completed when a client enters a case management

program is designed to determine case management and rehabilitation needs and should be coded as a Rehab Evaluation.

- Assertive Community Treatment (ACT) programs are authorized to provide primarily case management brokerage and individual and group rehabilitation, collateral and occasional crisis intervention services.
  - ACT programs are also authorized to provide an initial clinical assessment for the purposes of determining medical necessity, medication support services and some psychotherapy.
- Outpatient Biopsychosocial Rehabilitation Programs (OP/BPSR) are authorized to provide primarily individual and group rehabilitation, collateral, medication support, case management brokerage and occasional crisis intervention services.
  - OP/BPSR programs are also authorized to provide an initial clinical assessment for the purposes of determining medical necessity and some psychotherapy.
- Crisis Residential Programs are authorized to provide medication support services, and crisis residential services bundled as a 24-hour service.

Clinical Assessment for Medical Necessity

At the time a client is admitted to a program, clinicians shall perform a face-to-face assessment to ensure that each new client meets medical necessity criteria for specialty mental health services. According to service mix outlined above, the clinician shall complete the appropriate assessment form in CCBH Electronic Health Record (EHR) and ensure that all relevant clinical information is obtained and documented.

The following are specific procedures and criteria for each level of care:

Outpatient Providers

Within one month after the first planned visit, an Assessment and Client Plan shall be completed. If, after completing the assessment, the clinician determines that medical necessity criteria for specialty mental health services are not met, the client will be issued an NOA-A (see more complete description of the process in the Beneficiary Rights and Issue Resolution chapter of this Handbook) and his/her beneficiary rights shall be explained.

Strengths-Based Case Management

Strengths-Based Case Management services are delivered through specific freestanding programs that assist a client to access needed medical, educational, social, prevocational, vocational, and rehabilitative or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring services delivery to ensure beneficiary access to services and the services delivery system, monitoring of the clients

progress, and plan development.

Prior to admission to the program, each client must have a face-to-face assessment to establish medical necessity and to determine the presence of serious psychiatric disability and need for case management services. If the clinician determines that medical necessity criteria is not met and the client is not continuing to receive other Medi-Cal specialty mental health services, the client will be issued an NOA-A and their beneficiary rights shall be explained. If medical necessity criteria are met but the person is deemed not in need of case management services, an NOA-A is necessary only if the person is not receiving other Medi-Cal specialty mental health services. Due to limited resources, case management eligibility is prioritized for those persons who have the most severe psychiatric disabilities. Level of case management service intensity will be determined on an individual basis, with usual prioritization of the most intensive case management services established for those persons who have had the highest levels of Medi-Cal hospitalization and/or the most extensive amount of locked long-term care. Within one month of the client’s first planned visit, the Client Plan shall be completed.

OUTPATIENT Strengths-Based CASE MANAGEMENT PROGRAMS

Strengths-Based Case Management Service Eligibility

Due to limited resources, Strengths-Based Case Management eligibility is prioritized for those persons who have the most severe psychiatric disabilities. Most clients who receive case management services are Medi-Cal beneficiaries. However, case management services may also be provided to individuals who meet the clinical criteria and are indigent or otherwise unable to access case management services. Level of case management service intensity is determined on an individual basis, with prioritization of the most intensive case management services for those persons who have had the highest utilization of hospitalization and/or locked long-term care.

All case management clients must meet Title 9, Article 2, Section 1830.205 medical necessity requirements for outpatient mental health services and have major impairment in at least one area of life functioning. In addition, the person must demonstrate particular need for the additional services provided by case management services through one or more of the following:

- Has current LPS Conservatorship (may be a designated County Conservator or family member);
- Has been hospitalized or received involuntary psychiatric treatment within the past year;
- Is at high risk of admission to an inpatient mental health facility;
- Has a substantial need for supportive services (including care coordination and outreach mental health services) to maintain current level of functioning in the community, as evidenced by missed appointments, medication non-adherence, or inability to coordinate services from multiple agencies;

- Does not have a case manager from another program who is able to address mental health needs.

Clients receiving case management services are reviewed by the program's Utilization Review Committee (URC) to determine continuation of case management services and/or changes in the same level of case management.

Levels of Case Management

Three levels of case management services are available: Strengths-Based, Institutional and Assertive Community Treatment.

- ***Strengths-Based Case Management (SBCM)*** services provide a mix of mental health, rehabilitation and case management functions and have a staff-to-client ratio of approximately 1:25. Clients are typically evaluated in person at least monthly and by phone as clinically indicated, and it is expected that the case manager will have contact with significant others at least monthly. Services may be provided on a much more frequent basis, depending on client need.

- ***Institutional Case Management*** services are provided to clients who reside in the State Hospital or in out-of-county or in-county Institutes of Mental Disease (IMD) or Skilled Nursing Facilities (SNF). Services consist primarily of linking, coordinating and monitoring functions and have a staff-to-client ratio of up to 1:100. Clients are contacted at least quarterly.

- ***Assertive Community Treatment (ACT)*** services provide a mix of medication, mental health, rehabilitation and case management functions and have a staff-to-client ratio of approximately 1:10-12. Clients are typically evaluated in person at least bi-weekly and by phone as clinically indicated, and it is expected that the case manager will have contact with significant others at least monthly. Services may be provided on a much more frequent basis, depending on client need.

Referral Process for Case Management

Case management programs may receive referral information from any source. The program receiving the referral may determine that it is best able to serve the person, and will open the case. If the program receiving the referral determines the person might be better served through another provider, contact is made with the other program and the referral may be forwarded for review. Each program maintains a log of all referrals and referral dispositions.

To align the demand for case management services with the capacity of case management

programs and to assure connection with the program most relevant to the client's needs, referrals may be reviewed through the bi-monthly Case Management/ACT/FSP Providers Meeting Referrals among programs recommending transfer of a client (e.g., client has moved, client needs more or less intensive services than the program provides) may also be reviewed at this meeting.

Augmented Services Program

Designated case management providers may refer to Augmented Services Program (ASP). The goal of the Augmented Services Program is to enhance and improve client functioning through augmentation of basic Board and Care (B&C) services to specific individuals living in specific residential care facilities with which the county has an ASP contract. Emphasis is on developing client strengths, symptom management, and client self-sufficiency. Priority for ASP services is given to those persons in most need of additional services. Additional information about ASP may be found in the ASP Handbook, which is provided to all designated case management services eligible to refer to ASP.

In order to be eligible for funding from ASP, a client must:

- Have a primary diagnosis of a serious mental disorder;
- Have an active case open to A/OAMHS case management program and have been evaluated by their care coordinator to be in need of ongoing case management services. The assigned case manager is the only person who can submit a request for ASP services;
- Reside in an ASP contracted facility;
- Score in the eligible range on the ASP scoring tool; and
- ASP funds must be available for the month(s) of service.

The client's case must remain open to the A/OAMHS program that provides ongoing monitoring, care coordination and case management services in order for the ASP facility to continue receiving ASP funds for the client. The case manager notifies the ASP and the ASP facility prior to the time that the case management program closes a client's case.

Crisis Stabilization Services

"Crisis Stabilization" means a service lasting less than 24 hours (23.59 hours), to or on behalf of a beneficiary for a condition that required more timely response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: Assessment, collateral and therapy. Crisis Stabilization is distinguished from crisis intervention by being delivered by providers who meet the Crisis Stabilization contract, site, and staffing requirements described in Sections 1840.338 and 1840.348 of CCR, Title 9.

Crisis Stabilization is a package program and no other specialty mental health services are reimbursable during the same time period this service is reimbursed, except for Targeted Case Management. Crisis Stabilization shall be provided on site at a licensed 24 hours health care facility or hospital based outpatient program or a provider site certified by the Department or a Mental Health Plan (MHP) to perform crisis stabilization. CCR, Title 9 1840.338

Admission Criteria:

- Beneficiary must present with a mental health crisis for a condition that requires a more timely response than a regularly scheduled visit
- Must meet medical necessity

Services provided include, but are not limited to:

- Clinical Triage
- Face to Face psychiatric assessment
- Crisis Intervention
- Medication
- Collateral
- Linkage to other services as determined by Triage
- Disposition planning
- Voluntary and WI Code 5150 mental health services lasting less than 24 hours to a person in a psychiatric emergency due to a mental health condition.

Discharge Criteria:

- Discharge occurs when beneficiary no longer meets criteria for danger to others, danger to self and grave disability nor do they meet medical necessity.
- Can be discharged safely to a lower level of care.
- Must be connected to outpatient services, provided with referrals before discharge may occur.

A physician shall be on call at all times for the provision of those crisis stabilization services that may only be provided by a physician.

There shall be a minimum of one Registered Nurse, Psychiatric Technician or Licensed Vocational Nurse on site at all times beneficiaries are present.

At a minimum there shall be a ratio of at least one licensed mental health or waivered/registered professional on site for each four beneficiaries or other patients receiving crisis stabilization at any given time.

If crisis stabilization services are co-located with other specialty mental health services, persons providing crisis stabilization must be separate and distinct from persons providing other services.

Persons included in required crisis stabilization ratios and minimums may not be counted toward meeting ratios and minimums for other services. CCR, Title 9 1840.348

Crisis Stabilization is not reimbursable on days when Psychiatric Inpatient Hospital Services, Psychiatric Health Facility Services, or Psychiatric Nursing Facility Services are reimbursed.

The maximum number of hours for claimable for Crisis Stabilization in a 24 hour period is 20 hours. CCR Title 9 1840.368

Inpatient Services for Medi-Cal Beneficiaries

Pre-Authorization Through Optum

Inpatient service providers must secure pre-authorization for all inpatient services for Adults/Older Adults through the Optum Provider Line, 1-800-798-2254, option # 3, except:

- Emergencies/Urgent Services
- Clients directed by the San Diego County Psychiatric Hospital Emergency Psychiatric Unit (EPU) to the FFS Hospitals
- Intoxicated clients who will be assessed within 24 hours to determine the etiology of their symptomatology
- Medicare clients who convert to Medi-Cal on the Medi-Cal eligible date.

Medical Necessity for Adult/Older Adult Inpatient Services

Adult/Older Adult inpatient services are reimbursed by the MHP only when the following criteria are met, as outlined in Title 9, Section 1820.205.

- The client must have an included Title 9 diagnosis that is reimbursable for inpatient services as described in Title 9, Section 1830.205(1).

AND

Both of the following:

- The condition cannot be safely treated at a lower level of care;
- Psychiatric inpatient hospital services are required as a result of a mental disorder and the associated impairments listed in 1 or 2 below:

1. The symptoms or behaviors:
   a. Represent a current danger to self or others, or significant property destruction;
   b. Prevent the beneficiary from providing for, or utilizing, food, clothing or shelter;
   c. Present a severe risk to the beneficiary’s physical health;

   d. Represent a recent, significant deterioration in ability to function.

OR

2. The symptoms or behaviors require one of the following:
   a. Further psychiatric evaluation; or
   b. Medication treatment; or
   c. Other treatment that can be reasonably be provided only if the patient is hospitalized.

Inpatient Services for Non-Medi-Cal Eligible Clients (Non-insured)

Clients without Medi-Cal eligibility or the means or resources to pay for inpatient services are eligible for realignment-funded services and are referred to the San Diego County Psychiatric Hospital or to the Emergency Psychiatric Unit for screening. Both facilities are located at 3853 Rosecrans Street, San Diego, California 92110. The telephone number is (619) 692-8200. These are County-operated facilities.

Crisis Residential Services

The MHP, through its contracted provider, operates Crisis Residential Services, which are considered a "step down" or diversion from inpatient services. Crisis residential services are provided to both Medi-Cal and non-Medi-Cal clients who meet medical necessity and admission criteria. Referrals for services can be made directly to the Crisis Residential intake staff and do not require pre-authorization from Optum. More information about the locations and services provided by the Crisis Residential Programs may be obtained from the Network of Care website (www.networkofcare.org) or at the contractor's website, Community Research Foundation (www.comresearch.org).

Mental Health Services to Parolees

On a regular basis, individuals are discharged on parole from California State penal institutions; the list of institutions can be located on the Optum Website. In many instances, these persons are in need of mental health services. State law requires the California Department of Corrections to establish and maintain outpatient clinics that are designed to provide a broad range of mental health services for parolees. Sometimes, parolees are not aware of the availability of these services and present themselves to the County of San Diego Mental Health Services (MHS) outpatient clinics for their mental health needs. It shall be the responsibility of staff to ensure that all parolees from California State penal institutions who present for mental health services at a San Diego County program are appropriately served, or referred for service, in accordance with federal, State and County regulations as set out in the following guidelines:

Parolees who fall under the Forensic Conditional Release Program (CONREP) will be provided services in accordance with the current contract between the California Department of Health

Care Services and the County of San Diego.

1. Parolees who present for emergency mental health services shall be provided appropriate emergency assessment and crisis stabilization services, including processing for inpatient admission, if necessary.
2. Parolees with Medi-Cal coverage can receive inpatient services at any County-contracted acute care hospital. Indigent parolees can receive inpatient services at the San Diego Psychiatric Hospital.
3. Parolees who are Medi-Cal beneficiaries and who meet specialty mental health medical necessity requirements, as specified in CCR, Title 9, Section 1830.205, will be provided appropriate Medi-Cal covered mental health services.
4. Parolees, whether or not they are Medi-Cal beneficiaries, who do not meet specialty mental health medical necessity requirements will be referred for services at the local Department of Corrections-established outpatient mental health clinic, which is designed to meet the unique treatment needs of parolees, or to another health care provider.
5. Parolees who are not Medi-Cal beneficiaries and who do meet specialty mental health medical necessity requirements will be informed of the availability of services at the local Department of Corrections-established outpatient mental health clinic, and may choose to receive services from either County Mental Health or from the local Department of Corrections outpatient mental health clinic.
6. The California Welfare & Institutions Code, Section 5813.5 (f), explicitly prohibits the use of Mental Health Services Act (Proposition 63) funds for services to parolees. Managers of County and contracted programs which receive MHSA funding, are, therefore, responsible for ensuring that no MHSA funds are utilized for services to parolees from State prisons.

Mental Health Services to Veterans

Federal law has established the Department of Veterans Affairs (USDVA) to provide benefits to veterans of armed services. In 1996, the U.S. Congress passed the Veterans' Health Care Eligibility Reform Act, which created the Medical Benefits Package, a standardized, enhanced health benefits plan (including mental health services) available to all enrolled veterans. A prior military service record, however, does not automatically render a person eligible for these benefits. Only veterans who have established eligibility through the USDVA and have enrolled may receive them. In recognition of the fact that there are veterans in need of mental health services who are not eligible for care by the USDVA or other federal health care providers, the legislature of the State of California in September 2005 passed AB599, which amended section 5600.3 of the California Welfare and Institutions Code (WIC). Specifically, veterans who are ineligible for federal services are now specifically listed as part of the target population to receive services under the mental health account of the local mental health trust fund ("realignment"). California veterans in need of mental health services who are not eligible for care by the USDVA or other federal health care provider and who meet the existing eligibility

requirements of section 5600.3 of the WIC shall be provided services to the extent resources are available. It shall be the responsibility of staff to ensure that all veterans who present for mental health services at a San Diego County program are appropriately assessed and assisted with accessing their eligible benefits provided through the USDVA or other federal health care program or are referred and provided services through a San Diego County program.

Referral Process for Providing Mental Health Services to Veterans

1. **Adult/Older Adult Mental Health Services:** Staff will ask client if he or she is receiving veterans' services benefits. If the client state he or she is receiving benefits or claims to have serviced in the military, the staff will be responsible for completing the following procedure:
   a. The staff will complete "Request for Verification of Veterans Eligibility for Counseling and Guidance Services Fax Form" that will contain all appropriate demographic information and required client signature.
   b. The form shall be faxed to the Veterans Service Office for verification at (858) 505-6961, or other current fax number.
   c. If an urgent response is required, the mental health provider shall note on the Request Form in the Comment Section and contact the office by telephone after faxing the Request Form. All individuals who present for emergency mental health services shall be provided appropriate emergency assessment and crisis stabilization services, including processing for inpatient admission, if necessary.
   d. If the client meets the eligibility criteria for seriously mentally ill persons and is receiving veteran benefits but needs mental health services not offered by the USDVA, the client can be offered mental health services.
   e. If the client meets the eligibility criteria for seriously mentally ill persons and eligibility for veterans' services is pending, the client can be offered mental health services until the veterans services benefit determination is completed.

2. **Veterans Service Office:** The Veterans Service Office will receive the "Request for Verification Eligibility to Counseling and Guidance Services Fax Form" confirming client's eligibility or ineligibility for veterans' services and mail or fax findings to the County mental health program or contracted program.
   a. The Veterans Service Office will respond to the Request for Verification of Veterans Eligibility for Counseling and Guidance Services Fax Form within two to three business days upon receipt of the Fax Request.
   b. The Veterans Service Office will make referrals for benefit determination for an individual upon verification of eligibility status for veterans' services. The Veterans Service Office will also assist individuals in getting an appointment set up for evaluation of services if needed.

Missed Appointments and Follow Up Standard

All providers shall have policies and procedures in place regarding the monitoring of missed scheduled appointments for clients (and/or caregivers, if applicable). These policies and procedures shall cover both new referrals and existing clients, and at minimum, include the following standards:

- **For new referrals**: When a new client (and/or caregiver, if applicable) is scheduled for their first appointment and does not show up or call to reschedule, they will be contacted within 1 business day by clinical staff. If the client has been identified as being at an elevated risk[1], the client (or caregiver, if applicable) will be contacted by clinical staff on the same day as the missed appointment. Additionally, the referral source, if available, should be informed.

- **For current clients**: When a client (and/or caregiver, if applicable) is scheduled for an appointment and does not show up or call to reschedule, they will be contacted within 1 business day by clinical staff. If the client has been identified as being at an elevated risk[1], the client (or caregiver, if applicable) will be contacted by clinical staff the same day as the missed appointment. For clients who are at an elevated risk[1] and are unable to be reached on the same day, the program policy needs to document next steps, which may include consultation with a supervisor, contacting the client's emergency contact, or initiating a welfare check. Additionally, the policy shall outline how the program will continue to follow up with the client (or caregiver, if applicable) to re-engage them in services, and should include specific timeframes and specific types of contact (e.g., phone calls, letters). Staff should continue to monitor CCBH's Admissions report in an attempt to locate the client within the system of care (e.g., hospital, PERT or jail admissions).

All attempts to contact a new referral and/or a current client (or caregiver, if applicable) in response to a missed scheduled appointment must be documented by the program.

[1]**Elevated risk** is to be defined by the program and/or referral source.

Utilization Management

The MHP delegated responsibility to County-operated and contracted organizational providers to perform utilization management for, outpatient, crisis residential and case management services. Decisions are based on the medical necessity criteria delineated in Title 9 of the California Code of Regulations. The MHP monitors the utilization management activities of County-operated and contracted organizational providers to ensure compliance with all applicable State and federal regulations.

The Utilization Management for all service providers (outpatient, crisis residential, case management) includes procedures for establishing a Utilization Review Committee (URC), standards for participation in the URC, logs for URC activities, and standards for authorization.

Although there are slight variances in the utilization review process conducted by different service providers based on level of care, all programs participating in utilization review shall adhere to the following guidelines:

- Utilization review is a "never billable activity"
- URC logs are to be maintained at each program that record the results of the UR process
- URC logs are to be made available for review as needed by the MHP
- A clinician cannot participate in the authorization decisions regarding their own client
- Questions pertaining to the UR process should be directed to the Adult QI unit.

The Utilization Review procedures for Crisis Residential, Outpatient and Case Management programs are outlined below. All applicable forms and logs necessary to perform the Utilization Review process are located on the Optum Website.

Utilization Review for Crisis Residential Programs

Each crisis residential program, referred to as Short Term Acute Residential Treatment (START) program, shall convene a Utilization Review Committee (URC) to review all admitted clients in order to authorize services on an ongoing basis. The URC shall be multi-disciplinary and shall include, at a minimum, one licensed clinician designated by the Program Director to serve as the chair of the URC, as well as a minimum of two additional staff members who provide direct services or clinical oversight. Each URC shall meet 2-3 times per week, in conjunction with the START program's Treatment Coordination Committee (TCC) meeting. All clients will be reviewed by the program's URC within 3 days when possible, but no later than the 5th day after admission, in order to determine initial responsiveness to the services as well as set a projected length of stay and discharge date. Additionally, at a weekly minimum, all clients will be reviewed for ongoing medical necessity by the URC. Clients will be invited to attend the TCC/URC meeting when their treatment is being discussed. Should clients not want to attend the meeting with the URC members, staff will have input from the client prior to the meeting and will meet with the client again following the meeting in order to review the results. A "TCC/URC Record" will be created for each client and filed in the front of the progress notes section of the client's medical record. Additionally, "URC Minutes" will be maintained.

Utilization Review for Outpatient Programs

Beginning July 1, 2010 the MHP implemented a policy change affecting the Adult/Older Adult Mental Health Services (AOAMHS) utilization review process. The purpose of this new policy is to reinforce a change of the primary focus of current County Mental Health-funded (AOAMHS) outpatient clinic practices to recovery-oriented brief treatment and establish the requirement for implementing the Utilization Management process. In connection with this policy, clients who still require services but who are stabilized and able to function safely without formal County Mental Health outpatient services will be referred to a primary care setting or other community resources for services. It is the expectation of AOAMHS that most

clients shall receive brief treatment services that focus on the most critical issues identified by the clinician and client and that services will conclude when clients are stabilized.

Outpatient Guidelines:

I. Brief Solution-Focused Outpatient Services

Outpatient clinic services that shall be targeted as brief or time-limited include brief solution-focused individual and/or group treatment, individual and/or group rehabilitative services, and medication management as appropriate for stable clients who may be referred elsewhere for services. Services that may be delivered include:

- Clinical triage
- Assessment
- Possibility of up to 12 Therapy/Rehabilitative Sessions, which may include individual therapy or rehabilitation but with an emphasis on group/rehabilitation treatment as indicated. The number of services noted above (up to 12) is a recommendation and not a maximum number of services allowable.
- Group therapy
- Case Management
- Medication support as indicated

Clients receiving services which are Evidence-Based may be exempted from the following Utilization Management process with consent form the Program or Contract Monitor.
Clients will receive appropriate support and services to ensure that transition to other services are successful.

Clients who are referred elsewhere for medication or psychology services may still access County Mental Health-funded case management, peer support, and clubhouse services.

II. Initial Eligibility for Services

Initial Eligibility for Urgent and Routine Services will be based on meeting the criteria for:

- Title 9 Mental Health Medical Necessity,
- The AOAMHS Target Population-
  Individuals we will serve:
  1. Individuals with a serious psychiatric illness that threatens personal or community safety, or that places the individual at significant risk of grave disability due to functional impairment.
  2. People with a serious, persistent psychiatric illness who, in order to sustain illness stabilization, require complex psychosocial services, case management and/or who require unusually complex medication regimens. Required psychosocial services may include illness management; or skill development to sustain housing social, vocational and educational goals.

Individuals we *may* serve, to the extent resources allow, but who otherwise may be referred to other medical providers, include:

1. Individuals with serious psychiatric illness that may be adequately addressed in a primary care practice, either by a primary care practitioner or an affiliated mental health professional within a primary care practice setting, when the acute symptoms do not place the individual at risk of danger to self or others, and do not threaten the individual's ability to sustain independent functioning and housing within the community.
2. Individuals with lesser psychiatric illness, such as adjustment reaction, anxiety and depressive symptoms that do not cause significant, functional impairment that could be addressed within the context of a primary care setting or other community resources.

- A score on the **Milestones of Recovery Scale** (**MORS**) of 6-8

This criteria applies to all clients including Medi-Cal and indigent clients

III. Eligibility for Ongoing County or Contracted Program Outpatient Services

To continue beyond limited brief sessions clients shall be reviewed through a Utilization Management process and meet the following three criteria

1. Continued Mental Health Medical Necessity, with proposed intervention/s significantly diminishing the impairment or preventing significant deterioration in an important area of life functioning.
2. Meet Target Population Criteria
3. MORS- rating guideline of 5 or less **OR** an approved justification or on-going services for clients with MORS of 6, 7, or 8 which includes at least one continuing current Risk Factor related to client's primary diagnosis:
   a. Client has been in Long-Term Care, had a psychiatric hospitalization, or was in a Crisis Residential facility in the last year.
   b. Client has been a danger to self or to others in the last six months.
   c. Client's impairment is so substantial and persistent that current living situation is in jeopardy or client is currently homeless.
   d. Client's behavior interferes with client's ability to get care elsewhere.
   e. Client's psychiatric medication regimen is very complex.

IV. Utilization Management process:

In order to continue services, clients shall meet specific criteria and be reviewed through a Utilization management process which will be conducted internally at each program.

1. **All clients will be reviewed for on-going services through the MORS Rating process**

- A MORS rating will be completed on all clients- every six (6) months

2. **Utilization Management is based on MORS rating:**
   - Clients with a MORS rating of 1 to 5 will be qualified to receive ongoing services at the county or contracted outpatient clinic.
     - The MORS rating shall be kept in the client record
     - No other requirements
   - Clients with a MORS rating of 6 to 8 will be referred out of the county or contracted outpatient clinic for ongoing services unless an exception is made (see process noted below)
     - The MORS rating shall be kept in the client record
   - Exceptions for clients with a MORS rating of 6, 7 or 8
     - If a client receives a MORS rating of 6, 7, or 8 but the primary provider believes that the client should continue to receive services at the county or contracted outpatient clinic the primary provider shall complete the **Justification for On-going Services** (JOS) to continue sessions.
   - For subsequent treatment, client must meet both of the following criteria.
     1) Continued Medical Necessity with demonstrated benefit from services
     2) Meet Target Population Criteria
   - JOS shall be reviewed by program manager or designee
     - Program Manager or designee shall be licensed
     - Program Manager or designee may agree with primary provider or may recommend a different level of service.
     - Final determination shall be made after agreement by Program Manager or designee and primary provider.
   - The JOS shall be kept in the client record.
   - For clients with a MORS rating of 6, 7, or 8 the JOS process is to be completed every 6 months to determine continued eligibility for services. [Note that someone with a MORS rating of 8 should probably never be receiving services.]
   - **Programs are required to have a Utilization Review Committee in place to review records at least quarterly of a minimum of 5 clients whose MORS scores are not improving.**
     i. For clients whose MORS score is not improving a review of services and treatment plan shall be completed
     ii. Program may chose a minimum of clients to review but must review no less than 5
     iii. Programs are required to use the Utilization Review Committee Form to document the results of the Utilization Review Committee. QI may request a copy of the Utilization Review Committee Form be sent in to QI for monitoring purposes.

Other notable issues:

A. Clinicians shall clearly explain the process of services to clients upon intake.
B. Transition of existing clients: Effective 7/1/10, all current clients will be eligible for up to 12 brief individual therapy/rehabilitation sessions.
C. Clinicians shall clearly explain the process of services to clients upon intake. MORS shall be completed at admission and discharge and every 6 months.

Utilization Review for Case Management Programs

Each case management program shall convene a URC to review the provision of services on a concurrent basis. The URC shall decide issues of medical necessity, continuation of treatment and level of case management services. These decisions will be based on CCR, Title 9 Medical Necessity Criteria for diagnosis, impairment and interventions and Case Management Service Level Criteria. Decisions shall be supported by chart documentation of the client's individual functioning level, symptoms, and needs.

The URC shall consist of a minimum of three staff persons. The chair of the URC shall be a licensed/registered/waivered mental health clinician. Additional members shall be two or more staff who provides direct services or clinical oversight. A clinician shall not participate in the authorization decisions of his or her client. The QI unit may identify cases for review.

Initially, all clients who have been receiving case management services for more than two years shall be reviewed by the URC. The URC may only authorize up to one year of service at the same level. Conservatees do not have to be reviewed by the URC as they are reviewed annually by the Superior Court for continuing grave disability.

Prior to the utilization review of the client, the case manager will complete the *Six Month Review and Progress Note* verifying that the client meets medical necessity and service necessity criteria. This will summarize necessary information in order to assist with the URC review. Case managers will prepare cases for URC review by the first of the month of their annual review when the admission date to the current program was two or more years ago. The Program Manager/Supervisor will develop a list of clients due for review each month and will notify the case manager and the URC of the cases to be reviewed. The URC will notify the program and case managers of the date and time of the URC and have the charts gathered accordingly.

A *Case Management URC Record* shall be created for each client reviewed and filed in the front of the progress notes of the client's chart. This URC record will provide a summary of clinical information that supports the authorization decision. The *URC Minutes for Case Management* shall summarize the outcomes of the cases reviewed. These minutes will be maintained in a

designated file. The file shall be available for review as needed by the QI unit.

CHILDREN'S SYSTEM OF CARE

All authorization requirements in this section must be completed for all treatment clients even if the services will be funded by a source other than Medi-Cal, such as SB 163 and Mental Health Services Act (MHSA).

SCREENING

All referrals shall be **screened** by a clinician for appropriate level of care. Brief screening will be conducted without an episode opening and done on the phone unless the caregiver/youth is a walk in. Screening will facilitate timely and appropriate services which are family centered and support maximizing capacity at the Organizational Provider level. Direct referrals from the Access and Crisis Line (ACL) do not require program screening as screening was completed by the ACL, and therefore an assessment appointment shall be offered. To determine level of care, clinician brief screening (non-billable activity) will consider:

- Risk of Harm
- Functional Status
- Co-Morbidity
- Environmental Stress and Support
- Resiliency and Treatment History
- Caregiver Acceptance and Engagement

Based on brief screening, the appropriate level of care will be determined and communicated to the caregiver/youth. In addition to the use of natural community resources, the **Outpatient Level of Care** consists of:

Clinical Presentation	Appropriate Provider	Session Level	Notes
Mild / Non Complex calling for medical intervention or medication	Primary Care Physician (PCP) Medical Home Health Plans	TBD by medical team	
Mild / Non Complex need	Fee For Service (FFS) Network via Access and Crisis Line (ACL)	Roughly 6 to 12 sessions	Organizational Provider calls the ACL to inform of screening/recommendation
Moderate / Complex needs Medical Necessity met	Organizational Provider	Up to 13 sessions	UM is required annually, if 13 sessions are not used within 12 month

			period.
Severely Emotionally Disturbed (SED) Pervasive impairment	Organizational Provider	Up to 26 sessions	Require program level UM
Current Risk Factors	Organizational Provider Ancillary Services	27 Sessions and beyond	Require COR UM approval
Children/Youth who present with safety risk factors may require a 911 contact and/or an evaluation at the Emergency Screening Unit (ESU) to determine need for crisis stabilization or inpatient psychiatric care.			

For detailed information, instruction and requirements regarding authorization of outpatient services see the Optum Website. CYF Outpatient Level of Care, Brief Treatment Model.

MEDICAL NECESSITY

Provider must demonstrate that each client receiving Specialty Mental Health services meets medical necessity. Authorization is performed through the MHP Utilization Management Process, using Title 9 (Section 1830.205) Medical Necessity criteria as summarized below. A complete description of Title 9, Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services can be found on the State website at www.calregs.com. For a copy of Title 9, please call the State Office of Administrative Law at 916-323-6225. Services provided to clients are reimbursable when the following criteria are met:

Outpatient and Day Services Clients:

The client must have a diagnosis included in the current Diagnostic and Statistical Manual that is reimbursable for outpatient and day services as described in Title 9, Section 1830.205 (1).

AND

The client must have at least one of the following as a result of the mental disorder(s):
- A significant impairment in an important area of life functioning,
- A probability of significant deterioration in an important area of life functioning, or
- A probability that the client will not progress developmentally as is individually appropriate (for Medi-Cal beneficiaries under age 21).

AND

All of the following:
- The focus of proposed intervention is to address the impairment or potential impairment identified immediately above,

- The proposed intervention is expected to benefit the client by significantly diminishing the impairment or preventing significant deterioration in an important area of life functioning, and
- The condition would not be responsive to physical healthcare treatment.

Seriously Emotionally Disturbed (SED) Clients:

The priority population for Children's Mental Health Services, including clients seen under MHSA, is seriously emotionally disturbed (SED) children and youth. SED clients must meet the criteria for medical necessity and further are defined as follows (per California Welfare & Institutions Code Section 5600.3):

For the purposes of this part, seriously emotionally disturbed children or adolescents are those who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:

A. As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:
   - The child is at risk of removal from home or has already been removed from the home.
   - The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

B. The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

C. The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

OUTPATIENT SERVICES

Outpatient Short Term Model

One of the overarching Health and Human Services Agency (HHSA) principles is efficient and effective access to our target populations. CYFS clients receive brief treatment services that focus on the one or two most important issues identified by the client/family and conclude when those are stabilized. The short term, focused model shall be communicated at the onset of

treatment so the client/family can maximize use of sessions and be prepared for conclusion of treatment.

Clients who meet the criteria for Title 9 medical necessity shall be eligible for up to 13 individual treatment sessions or up to 18 exclusively family and/or group treatment sessions (within a 12 month period). This will apply to Medi-Cal and MHSA (indigent) Severely Emotionally Disturbed (SED) clients. Additional sessions may be authorized as clinically indicated. Utilization Management shall be completed at the program level by a licensed clinician.

For detailed information and requirements regarding authorization of outpatient services, see the Optum Website.

Authorization for Reimbursement of Services

The San Diego County MHP defines Children, Youth and Families Services (CYFS) clients as children and youth up to 21 years of age. Providers shall evaluate TAY clients to determine if child or adult network of care would best serve their needs as well as explore TAY specific resources. Clients and families may access the services of organizational providers and county-operated facilities in the following ways:

- Calling the organizational provider or county-operated program directly
- Walking into an organizational provider or county-operated program directly
- Calling the Access and Crisis Line at 1-888-724-7240

A client/family may access services by calling or walking into an organizational provider or county-operated program; the client shall be screened and when applicable assessed by the provider. After completion of an assessment and when additional services are offered, that provider is responsible for entering administrative and clinical information into all the appropriate fields in the Management Information System (MIS). Providers must register clients, record assignment and service activities, and update the CSI information in MIS. (See the Management Information System section of this handbook for a description of how MIS supports these provider activities.)

If, after completing the assessment, the clinician determines that medical necessity criteria for specialty mental health services are not met, the Medi-Cal beneficiary shall be issued an **NOA-A***)* and **NOA-Back** (which must also be documented in the **NOA Log** tab of the Quarterly Status Report and their beneficiary rights shall be explained. If a client will receive day services (either intensive or rehabilitative) on the same day that the client receives Mental Health Services (Individual, Group, Family, or Collateral. Etc.), authorization for the Mental Health Service must be determined in accordance with the Day Treatment Ancillary UR process applicable to

outpatient providers. Authorization is obtained from Optum through the day treatment provider. (See Utilization Review.)

If the Access and Crisis Line (ACL) refers a client to an organizational provider or to a county-operated facility, ACL enters the client information in the MIS. The provider is then responsible for insuring all client information is correct and complete. The provider is also responsible for recording all ongoing activity for that client into the MIS. This information includes, but is not limited to, assignment and service activities, the primary diagnosis, the name of the single accountable individual, and all client assignment closings.

Utilization Management

The MHP has delegated initial responsibility to outpatient County operated and contracted organizational providers to perform utilization management for specialty mental health services, outpatient services, medication services, and case management services. Authorization decisions are based on the medical necessity criteria delineated in Title 9 of the California Code of Regulations. Each delegated entity shall be accountable to the Behavioral Health Services Division Director and shall follow the Utilization Management processes established for children's mental health programs.
At the time a client is admitted to a program, clinicians shall perform a face-to-face assessment to ensure that each new client meets medical necessity criteria and SED when applicable for specialty mental health services. The clinician shall complete the County's applicable Behavioral Health Assessment Form and ensure that all required domains are completed.

The Utilization Management Committee operates at the program level and must include at least one licensed clinician. The Utilization Management Committee bases it decisions on whether medical necessity is still present, whether the proposed services are likely to assist in meeting the Client Plan goals, and additional criteria from the *Utilization Review Request and Authorization.* To assist in its determination, the Utilization Management Committee or clinician receives a UM Request and Authorization form (which reports current client functioning in quadrants for various domains) and a new Client Plan to cover the interval for which authorization is requested. Medication only clients are not included in the Utilization Management process as they are subject to medication monitoring. For detailed information and requirements regarding Utilization Management for outpatient programs see the Optum Website.
Secondary UM review is reserved for clients who demonstrate ongoing, high severity and require additional services to maintain safety. The level of review generally occurs at 26 session level and conducted by the MHP through the COR. Providers shall monitor percentage of initial and secondary UM (reported in QSR) to evaluate compliance with brief treatment philosophy.

If client is concurrently provided day and outpatient services, then ancillary authorization must occur through day program and Optum because the day services cycle supersedes outpatient UM. In these cases the outpatient program must also complete a UR in accordance with the procedure described in CYF Outpatient Level of Care.

Medication Only Services

The MHP has delegated the responsibility to outpatient County operated programs and contracted providers to assure proper enrollment, services and monitoring of children and youth who are receiving only medication support and have no therapist or case manager involved.

Children and adolescents, as a result of their rapid development, should receive a thorough assessment as a part of any clinical service, and for most, services should include a full spectrum of treatment services, including psychotherapy, designed to reduce or ameliorate symptoms and functional impairment. However, a small number of youth may have chronic conditions for which periodic breaks in treatment are appropriate. For those that require ongoing medication treatment even during such a hiatus, outpatient providers shall leave the assignment open with the psychiatrist designated as the primary server. Such cases are not subject to utilization review/management but are subject to medication monitoring and additional peer review if the situation is unusually prolonged. Children and adolescents who have completed an assignment of psychotherapy and been retained as a medication only client must have rapid access to a resumption of therapy if a need should arise.

Procedure for Medication Only Clients:

1. Clients who have never had an open assignment in the program receiving the referral should not be opened as medication-only clients without previous approval from the Contracting Officer's Representative (COR). In these cases a complete and up to date Behavioral Health Assessment must be in the client chart. Additionally, once treatment plans are implemented in the Management Information Service (MIS) or Electronic Health Record (EHR) a client plan must be in place to cover medication only services.

2. When the child or adolescent has a therapist in a different organizational provider program, that program shall be contacted as to why the needed medications are not being provided by the assigned therapist's program

3. If the child's therapist is a fee-for-service provider, the child's legal representative shall be provided the number to the Access and Crisis Line for assignment to a fee-for-service psychiatrist.

4. In the event that service goals have been met, that a Utilization Review/Management (UR/UM) Committee has denied further therapy sessions, or if in the opinion of the therapist,

client, and caregiver, a break in psychotherapy treatment is appropriate, the client shall be assessed for the need for ongoing medication support. Criteria for requiring such support shall include:

a) The client has been stabilized on a medication regime for a minimum of three (3) months under the care of the provider's staff psychiatrist;
b) In the opinion of the prescribing psychiatrist, the child or adolescent would experience an exacerbation of symptoms or impairment if removed from the medication;
c) The child's primary care physician is unable or unwilling to continue the medication, even with consultation from the program psychiatrist;
d) The continuation of medication support is desired by the client and caregiver; and
e) For School Based clients, clinician shall have the outpatient services removed from the student's Individual Education Program (IEP).

5. When the decision is to continue the case as medication-only, within the same Unit/SubUnit, the case shall remain open but the previous therapist shall complete a discharge summary stating that continuing medication support is necessary. In the MIS, the name of the server shall be updated to reflect the name of the physician. Crisis Intervention visits may be offered by the previous therapist or other staff during a medication-only interval without utilization review/management requirements.
6. Documentation for a medication only case shall include: a complete and up to date Behavioral Health Assessment, Psychiatric Assessment (completed on initial medication evaluation and for each follow up medication management session), and an active Client Plan. Medication only cases are exempt from completion of Child and Adolescent Measurement System (CAMS) and Youth Services Survey (YSS). Children's Functional Assessment Rating Scale (CFARS) is to be completed and entered into Data Entry System (DES) annually.

7. Medication-only cases shall be billed using only the range of Medication Support service codes, except in the case of Crisis Intervention. In the event that case management or formal assessment is required in addition to Medication Support, the case no longer meets the criteria of medication-only and routine charting and authorization procedures shall be followed.

8. Medication-only cases are not subject to UR/UM, but cases open in this status for 12 months or more shall be reviewed annually by the Medication Monitoring Committee. When reviewed by the Medication Monitoring Committee, the reviewer shall consider:
   a) Whether the child's age, health status, and emotional functioning continue to support the need for ongoing medication treatment.
   b) Whether a return to active psychotherapy is indicated.

9. If a client who has been receiving medication-only services should experience an increase in symptoms or impairment, or if the course of the client's development suggests that an interval of active psychotherapy is likely to be helpful, the case shall be reviewed to determine if a current UR/UM authorization is in place.
   a) When authorization is in place, therapy may resume, however a new Client Plan is indicated.
   b) When authorization has expired, the UR/UM Committee must first authorize services for billing of therapy to resume.
   c) In the MIS (EHR) the name of the server shall be updated to reflect the name of the current clinician.

SCHOOL INTERFACE

Effective 7-1-12 CYFS is no longer contracted through County Office of Education to provide Educational Related Mental Health Services (ERMHS) which is in line with repeal of AB2726/3632 in October of 2010. Students with mental health needs are assessed through the school system and when appropriate are offered related services through the school district so they can benefit from their education. Students receiving services through the school may also access CYFS services when they meet specialty mental health criteria through the County system. CYFS standard of practice is to offer a full range of services which may include medication services as well as services which are educationally related and therefore coordination of care with the school continues to be critical.

DAY REHABILITATION AND DAY INTENSIVE

Definitions for Day Treatment:

Day Rehabilitation - a structured program of rehabilitation and therapy to improve, maintain or restore personal independence and functioning, consistent with requirements for learning and development, which provides services to a distinct group of beneficiaries and is available at least four hours and less than 24 hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral. See a more detailed list of required services below.

Day Intensive - a structured, multi-disciplinary program of therapy which may be an alternative to hospitalization, avoid placement in a more restrictive setting, or maintain the beneficiary in a community setting, with service available at least three hours for half-day programs, four hours for full-day programs and less than 24 hours each day the program is open. Service activities may include, but are not limited to assessment, plan development, therapy, rehabilitation and collateral. See a more detailed list of required services below.

Therapeutic Milieu - a therapeutic program with specified service components and specific activities performed by identified staff. The program must operate for more than four continuous hours for a full-day program and a minimum of three continuous hours for a half-day program. The therapeutic milieu must be made available for at least a weekly average of three hours per day for full-day programs and an average of two hours per day for half-day programs. The milieu includes staff and activities that teach, model and reinforce constructive interactions, includes peer and staff feedback to clients on strategies for symptom reduction, increased adaptive behavior, and stress reduction, and includes client involvement and behavior management interventions

Authorization of Reimbursement of Services

Prior to admission to the program, each client must:

- have a face-to-face assessment to establish medical necessity.
- The assessment must document a recommendation for day program ,
- document lower levels of care have been tried unsuccessfully or would be unsuccessful if attempted,
- highly structured mental health program is needed to prevent admission to a more intensive level of care.

The Initial Day Program Request (DPR) must be completed/submitted along with a Specialty Mental Health Services DPR if the client receives ancillary services on the same day as day program services. Continued requests that are made must be accompanied with a Specialty Mental Health Service (Ancillary) DPR if applicable. The Ancillary DPR should be filled out by mental health outpatient providers and coordinated through the Day Program. Utilization review will be completed by Optum according to necessity criteria for the level of day service, Initial DPR, Specialty DPR, and Continued DPR can all be found on the Optum Website under UCRM tab.

These service criteria essentially state that the client cannot be served at a lower level of care and that a recommendation for day services has been made. Day services must be reauthorized every 3 months for day intensive and every 6 months for day rehabilitative. If medical or service necessity criteria are not met, the Medi-Cal client will be issued an NOA-A (which must also be documented in the NOA log) and the beneficiary rights shall be explained. In the event that the provider has received a denial of authorization from Optum, a **NOA-B** shall be issued by Optum.

Notes:
*DPRs are to be completed for all day services clients (optional for clients from out-of-county; who require a Service Authorization Request (SAR))

** Note: it is the responsibility of each program to determine insurance coverage (or lack of) in order to decide which process to follow:

*DPRs are faxed to Optum for review for the following situations:

- Client has Medi-Cal
- Clients with primary private insurance and secondary Medi-Cal AND the primary private insurance has provided a denial of payment (only then can Medi-Cal be billed for services)

*DPRs are NOT sent in to Optum for the following situations:

- Clients with no insurance
- Clients with a primary private insurance
- Clients with a primary private insurance and secondary Medi-Cal (AND the parents have declined to sign an Assignment of Benefits)

*Initial authorizations may not be submitted prior to the opening of the assignment.

*Authorization cycles are based on months and not days (i.e. for Day Intensive an authorization cycle may look like: Initial DPR 1/1/08-3/31/08 and Continued DPR 4/1/08-6/30/08. For Day Rehabilitation Initial DPR 1/1/08- 6/31/08, Continued DPR 7/1/08 – 12/31/08, etc.).

*Optum will review the DPR and determine authorization within 14 business days. The provider may check directly in the MIS for authorization or contact Optum if there are questions. Authorization letters will no longer be sent out to the program.

*Authorization will include day service and ancillary services for each client. Authorizations for day treatment and ancillary services are entered separately based on the timeline of the receipt of the request by Optum.
*Letters of denial of authorization will be sent to the program for the following reasons:

- Client does not show as Medi-Cal eligible
- Client has a primary private insurance
- Client has a primary private insurance and secondary Medi-Cal – but no denial of payment has been provided by the private insurance (therefore Medi-Cal may not be billed).

*Programs are responsible to check on a monthly basis all Medi-Cal and UMDAP clients for eligibility and update the MIS as appropriate.

* DPRs should be filed in the medical record in the Plans section, or be accessible upon request.

* Retroactive authorizations should not be requested for services more than 9 months in the past. Inform your COR via e-mail when submitting a retroactive authorization request.

** If any of the above is not done correctly, Optum will return the DPR for correction and services will not be authorized until the corrections are made and the form is faxed back to Optum for review.

*****When the Specialty Mental Health (Ancillary) DPR is done incorrectly, Optum will send the DPR to the Day program with whom the outpatient program is coordinating.**

If you have any questions regarding the DPR process including following up with authorization questions, please contact: Optum at (800) 798-2254 option #4.

Program Monitoring – The Quality Management Unit will monitor Day Treatment Programs in accordance with state standards. See attachments from DMH Letters and Notices for Day Treatment.
Monitoring includes but it not limited to:

- the annual collection of schedules, program descriptions and group descriptions for approval
- programs must submit any changes to the schedule, or group descriptions for review and approval

Utilization Review

Utilization review of day intensive and day rehabilitation services for Medi-Cal clients is delegated to Optum.

OUT OF COUNTY MEDI-CAL CLIENTS

Authorization of Reimbursement of Services
Children in foster care, Aid to Adoptive Parents (AAP), and Kinship Guardianship Assistance Payment Program (KinGAP), when placed outside their country of origin have had difficulty receiving timely access to specialty mental health services. Senate Bill (SB) 785 intends to improve the timely access to these services by transferring the responsibility for the provision of specialty mental health services to the county of residence of foster, AAP, and KinGAP children. DMH Information Notice No. 08-24 and 09-06.

Outpatient Programs Procedure(s) for Medi-Cal Eligible Children in a Foster Care, Aid, AAP, and KinGAP:

1. Child Welfare Services (CWS) Social Worker from the county of origin instructs legal guardians to contact San Diego Administrative Services Organization (ASO), at 1-888-724-7240 for services referrals. The ASO makes a referral to a Fee-For-Service (FFS) or an organizational provider.

2. The program providing the services will submit the Service Authorization Request (SAR*)* to the county of origin for authorization and signature.
3. The County of San Diego provider will provide services, if the child meets Medical Necessity Criteria and the county of origin authorizes the provision of services. The service provider is required to inform the child welfare agency of the county of origin of the services being provided, if requested and if the information is available, in accordance with the privacy standards contained in the Health Insurance Portability and Accountability Act (HIPAA) and Medi-Cal confidentiality requirements.
4. If county of origin SAR authorization is delayed, services may be provided when the reason for delay is administrative in nature and not a clinical denial.
5. Services shall be entered into the CCBH Management Information System (MIS) by the San Diego provider.
6. The County of San Diego will submit the claim for services directly to the State Department of Health Care Services via the MIS.
7. Service provider shall inform COR of any out of County Clients served.

There are in essence two types of OOC Medi-Cal clients.

1. OOC clients who fall under one of three aid codes (Foster Care, AAP, KinGAP). Those clients require a SAR through the County where the Medi-Cal is from. They are also subject to our local UM process.
   Services shall be entered into MIS.

2. OOC clients who do not fall under one of those codes need to have their Medi-Cal shifted to San Diego in order for us to serve them. Programs need to get authorization from COR to serve those kids prior to Medi-Cal shift and if that authorization is granted prior to the Medi-Cal shift it is with the expectation that program is actively and promptly working with guardian to have Medi-Cal shift to San Diego. No need to complete a SAR; follow local UM process

SARS

1. SAR format is now routinely asking for one-year authorization; San Diego provider continues to follow local UM in addition to SAR.
2. SAR is for medically necessary specialty mental health services. However, the Counties are reviewing specifics and it has been determined that at this time a SAR will only be issued for basic outpatient services – not for Day Services, WRAP, TBS, ICC, IHBS or other intensive services.

Day Programs Procedure(s) for Medi-Cal Eligible Children in Foster Care Aid, AAP, and KinGAP:

1. Day Programs will inform their COR when serving out of county Medi-Cal clients.

2. Day Programs first priority is to serve San Diego County clients then out of county Medi-Cal clients with Foster Care Aid, AAP, and KinGAP codes.
3. Day Programs will coordinate with county of origin for SAR authorization. If county of origin SAR authorization is delayed, services may be provided when the reason for delay is administrative in nature and not a clinical denial.
4. Program submits signed SAR to Optum.
5. Program additionally submits a DPR to Optum. A DPR is not required when the following information is provided with the signed SAR:
   a. Unit and subunit on the SAR
   b. CFARS Rating (new CFARS Rating completed at each UM cycle)
6. Services are entered into the CCBH (MIS) by the San Diego provider.
7. The County of San Diego will submit the claim for services directly to the State Department of Health Care Services via the MIS.
8. All County of San Diego paperwork must be completed as well as any alternate forms/information required by the county of origin.
9. When day services are provided out of county, an alternative Day Program Request Form may be used if it contains all required elements. Approval for its use is to be obtained by either the COR or Program Manager of Quality Improvement.

Children/youth with out of county Medi-Cal who do not fall under Foster Care Aid, AAP, and KinGAP Codes shall be evaluated to determine if their Medi-Cal status is in the process to shift to San Diego County prior to providing services. Prior written COR authorization shall be obtained to enroll in services; and a SAR submitted to county of origin. Provider shall actively work with family to transition Medi-Cal to San Diego County. Services shall be entered in the MIS.

THERAPEUTIC BEHAVIORAL SERVICES (TBS)

Clients are referred to New Alternatives, Inc. (NA), who is the point of contact for Therapeutic Behavioral Services (TBS). The referring party may include COSD SOC, CWS and Probation Department. The referring party will complete and return a referral form and Release of Information (Appendix A.D.21) to the Point of Contact/Referral Specialist. Referrals are then screened and assessed by Point of Contact/Referral Specialist for eligibility criteria according to California Department of Health Care Services guidelines provided in DMH Letter 99-03 and DMH Notice 02-08. Purpose of screening is to ensure client/family is Medi-Cal eligible and to confirm the client/family willingness to participate in the services. Point of Contact/Referral Specialist will then assign client/family to a Case Manager and the referring party is updated in the process. The provider assigned to the client/family will conduct assessment to ensure client meet the class, service, and other TBS criteria prior to services being delivered.

TBS brochures are available in English. See Optum Website under Beneficiary Tab.

Utilization Review

Authorization management for extended Therapeutic Behavioral Services is retained by the MHP. If a client requires more than 25 hours of coaching per week of TBS, the Contractor shall contact COR for approval. But if client requires more than 4 months of services, provider will use internal/tracking request system that does not require COR approval. Authorization is not needed for "stabilization services" where the client is receiving one to two hours a week for a couple of weeks to ensure stability of treatment gains.

Authorization for services for San Diego clients placed out of county are referred to the COR for authorization for TBS services.

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** to children and young adults (under age 21) who qualify for Medi-Cal EPSDT services and their caregivers or guardians 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, Short Term Residential Therapeutic Program (STRTP) 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

Pathways to Well-Being

Overview

Pathways to Well-Being was prompted by the Katie A. class action suit, which was filed in 2002 against the County of Los Angeles and the State of California by a group of foster youth and their advocates, alleging violations of multiple federal laws. The suit sought to improve the provision of mental health and supportive services for children and youth in, or at imminent risk of placement in, foster care in California. Katie A, the youth identified in the name of the lawsuit, was a foster youth in the County of Los Angeles who had over 30 out of home placements, including psychiatric hospitalizations and placement in residential treatment,

between the ages of 4 and 14 years-old, due to unmet behavioral health needs. The State of California settled its portion of the lawsuit in December 2011 and, in March 2013, issued the Core Practice Model (CPM) Guide. Pathways to Well-Being was implemented in March 2013 in the County of San Diego as a joint partnership between Behavioral Health Services (BHS) and Child Welfare Services (CWS) in collaboration with Probation. The County of San Diego is dedicated to collaborative efforts geared toward providing safety, permanency, and well-being for youth identified as having complex or severe behavioral health needs and to ensure long term permanency within a home-like setting. Pathways to Well-Being services are available to youth up to age 21 across the System of Care, including Transitional Age Youth (TAY) who are involved in either the Children's System of Care or the Adult/Older Adult System of Care.

Pathways to Well-Being includes services that are needs driven, strengths-based, youth and family focused, individualized, culturally competent, trauma informed, and are delivered in a well-coordinated, comprehensive, community-based approach with a central element of engagement and participation of the youth and family. These values mirror our System of Care Principles.

Serving Youth With an Open CWS Case

Upon intake and at each assessment interval clients are screened for CWS involvement which is captured in the Behavioral Health Assessment (BHA). When a youth has an open CWS case, the BHS provider completes the Eligibility for Pathways to Well-Being & Enhanced Services form within 30 days of client episode opening, during reassessment, and at discharge. The form is updated during changes in the course of treatment, such as the opening or closing of a CWS case or change in placement or treatment provider. This form indicates if a client is Eligible for Pathways to Well-Being (Class), or Eligible for Enhanced Services (Subclass). Clients who are identified as Pathways to Well-Being (Class), but do not meet the eligibility criteria for Enhanced Services (Subclass), are not required to receive the services mentioned below, but are identified in Cerner Community Behavioral Health (CCBH) in Client Categories Maintenance (CCM) as Class and ongoing collaboration between the provider and Child Welfare Services will occur. (Form located at BHETA PWB website, http://theacademy.sdsu.edu/programs/BHETA/pathways.html under Tools and Forms)

For all clients with an open CWS case, either Class or Enhanced Services (Subclass):

- Identify in the Client Categories Maintenance (CCM) area of CCBH (aka "flip the switch") as either Class or Enhanced Services (Subclass)

- Submit the Progress Report to Child Welfare Services form to Child Welfare Services, Protective Services Worker (PSW) at intake, quarterly and at discharge. This form contains the client's diagnosis which the PSW will share with the courts. It is critical that the clinician inform and prepare the child and caregiver of the nature of shared information for clients with an open CWS case. (Form located at BHETA PWB website, **http://theacademy.sdsu.edu/programs/BHETA/pathways.html** under Tools and Forms).

Enhanced Services (Subclass)

Youth (up to 21 years of age) are considered Eligible for Enhanced Services (Subclass) **if the following criteria are met:**

1. Open CWS case (including voluntary) **and**
2. Meets the medical necessity criteria (Title IX, Section 1830.205(1) or 1830.210) **and**
3. Has full-scope Medi-Cal (Title XIX) **and, either**
4. Has experienced two or more placements within 24 months due to behavioral health needs

or

5. Currently being considered for or receiving or recently discharged from a higher level behavioral health or related services (generally within 90 days)

If criteria 1 and 2 are met, but 3, 4, or 5 are not met, the youth will be considered PWB Class.

Child and Family Team

Under Pathways to Well-Being, all children entering the CWS system receive a mental health screening and, based upon need, are part of a collaborative, youth and family-centered teaming process, referred to as the **Child and Family Team (CFT)**. There is a distinction between a Child and Family Team, which is a team of people identified to ensure the youth has access to appropriate mental health and supportive services in order to ensure safety, permanency, and well-being, and the Child and Family Team meeting, which is one way in which the team members communicate. The team composition is guided by the youth and family needs and preferences. **For Enhanced Services (Subclass) identified youth, the initial CFT meeting must occur within 30 days of determining eligibility and follow up CFT meetings should be conducted at a minimum of every 90 days.** Following a CFT meeting, all members of the team should receive a copy of the **Pathways to Well-Being Child and Family (CFT) Progress Summary and Action Plan** which includes specific action steps and timelines developed for the

team members. A CFT evolves over time, as effective strategies are put in place and goals are achieved. The BHS clinician completes an **Individual Progress Note/ICC Note** that is provided to the PSW who utilizes the information for court reports.

(Forms are located at BHETA PWBwebsite, **http://theacademy.sdsu.edu/programs/BHETA/pathways.html** under Tools and Forms)

The CFT is comprised of the following members ([M]indicates mandatory member):

- Child/youth/TAY[M]
- Family/caregiver[M]
- Child Welfare Services (CWS) social worker[M]
- Behavioral Health Services (BHS) provider[M]
- Probation[M] (when youth is a ward of the court)
- Informal supports identified by the youth and/or family
- School personnel
- Other service professionals who are working with the youth and family towards long term safety, permanency, and well-being

All youth that meet Enhanced Services (Subclass) eligibility will have a **Care Coordinator.** BHS and CWS will work together to identify the Care Coordinator and this person will take the lead in identifying CFT members with input from the youth/family. The Care Coordinator is also responsible for adherence to CFT meeting requirements and timelines. A Care Coordinator serves as the single point of accountability to ensure that medically necessary services are accessed, coordinated and delivered in a strength-based, individualized, family/youth driven and culturally and linguistically relevant manner and that services and supports are guided by the needs of the youth.

Intensive Care Coordination (ICC)

Eligible for Enhanced Services (Subclass Intensive Care Coordination (ICC) Service Code (SC) 82/882 must be provided to all youth that are)**.** ICC is linked to teaming/collaboration and provided through the (CFT). ICC is an intensive service that is used for the identification and coordination of ancillary supports and systems which assists with stabilization. ICC services are offered to clients with significant and complex functional impairment which call for a high level of care coordination. Examples of ICC include: facilitating or attending a collaborative team meeting or Child Family Team Meeting, collaboration with formal and/or informal supports to ensure the complex behavioral health needs of youth are met and collaboratively developing Client Plan/Teaming Goals.

ICC may be indicated when a youth is:

- At risk of psychiatric hospitalization
- Recently discharged from hospitalization (generally within last 90 days)
- Recently discharged from Emergency Screening Unit (generally within last 90 days)
- At risk of needing crisis stabilization
- Placed in, being considered for, or recently discharged from a RCL 10 or above facility/Short Term Residential Therapeutic Programs (STRTP)
- Receiving services from a high intensity treatment program (see ICC Service Code 82 definition at BHETA PWB website, **http://theacademy.sdsu.edu/programs/BHETA/pathways.html** under ICC and IHBS Expansion)

Other considerations for when to provide ICC are outlined in the California Department of Health Care Services (DHCS) Medi-Cal Manual, Second Edition (09/21/2016). The manual includes considerations such as multiple mental health diagnosis, recent emergency room visits, and specifications related to the 0-5 population. For more specific information, see link in the resources section below for the revised Medi-Cal Manual.

Intensive Home-Based Services (IHBS)

Intensive Home-Based Services (IHBS) SC83/883 is an ancillary service that may be provided when indicated, if a youth is receiving ICC. IHBS are individualized, strength-based interventions designed to improve mental health conditions that interfere with a child/youth's functioning and are aimed at helping the child/youth build skills necessary for successful functioning in the home and community. IHBS are also available to improve the family's ability to help the child/youth successfully function in the home and community. IHBS are offered to clients with significant and complex functional impairment which require more intensive services. These services are primarily delivered in the home, school or community and outside an office setting. Examples of IHBS include: providing support to address obstacles that interfere with being successful in the home, school and community such as maintaining housing, gaining employment and/or achieving educational goals.

For youth receiving ICC and IHBS, a Client Plan update needs to be completed in order to include SC 82 ICC and SC 83 IHBS. There are situations where ICC or IHBS is a lock out, at

which time the non-billable ICC (SC882) or IHBS (SC883) are utilized. Refer to the Documentation Manual for lock out situations (see link below for Documentation Manual).

ICC/IHBS Expansion

As of July 1, 2016 Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS) availability was expanded, through the EPSDT benefit, to all youth under the age of 21 who are eligible for the full scope of Medi-Cal services and who meet medical necessity for these services.

Youth not involved with CWS may be provided ICC and IHBS services as clinically indicated, but the mandatory provision of CFT meetings and timelines associated with Enhanced Services (Subclass) do not apply. Furthermore, non-CWS youth do not need to be identified in the CCM (do not "flip the switch"). For youth receiving ICC and IHBS services under the expansion, a **Client Plan** update needs to be completed in order to include SC 82 ICC and SC 83 IHBS.

Data Reporting

The county and state require data collection associated with Pathways to Well-Being as it pertains to Class and Enhanced Services (Subclass), as well as tracking of CFT meetings. BHS providers utilize internal tracking methods such as CCBH reports to monitor Class and Enhanced Services (Subclass) status and ICC/IHBS services that are provided in a program. This information is reported in the data tab under Pathways to Well-Being in the Quarterly Status Report (QSR).

Bulletins

Bulletins are used by the BHS Pathways to Well-Being Team to inform and provide procedures associated with Pathways to Well-Being. Bulletins can be found on the BHETA website and include the following: (see BHETA PWB website, **http://theacademy.sdsu.edu/programs/BHETA/pathways.html** under Pathways Bulletins)

- Blanket Court Order (9-3-14)
- Katie A. (KTA) Service Summary Codes (1-20-15)
- "Flipping the Switch" Reminders (10-14-15)
- Making Changes in Client Categories Maintenance (10-14-15)
- Open CWS Cases: Consent to Treat and Release of Information (4-16-15)
- The Importance of a Warm Handoff (4-23-15)

- Child and Family Team Meeting Time Lines (7-6-15)
- Education Representatives and Child and Family Teams (7-10-15) and Pathways Education Letter Template (7-10-15)
- Pathways eLearning Booster (10-14-15)
- New Service Indicator – CFT Meetings (1-26-16)
- eLearning Booster Reminder (2-01-16)
- Identifying the Assigned Protective Services Worker (5-5-16)
- Cases in Investigations Status (5-10-16)
- Foster Youth Mental Health Bill of Rights (6-24-16)
- Entering End Date in CCM at Discharge (9-7-16)

Trainings

All direct service staff shall obtain the following on-line trainings from the BHETA website within 60 days of hire:

- Overview of Children Youth and Families Behavioral Health Services
- An Introduction to Pathways to Well-Being: Understanding the Katie A. Lawsuit and the Core Practice Model
- CWS 101 An Overview of Child Welfare Services in San Diego County

Additionally, for programs who routinely serve Enhanced Services (Subclass) members shall have primary staff attend the applicable Pathways to Well-Being classroom trainings which may include:

- Pathways to Well-Being One Day Overview training
- Pathways to Well-Being Child and Family Team (CFT) Facilitation training

Forms

Client related forms specific to Pathways to Well-Being which must be completed include the following: (Forms are located at BHETA PWB website, **http://theacademy.sdsu.edu/programs/BHETA/pathways.html** under Tools and Forms)

Form	**Date** (check BHETA website for most current version)	**Details**

Eligibility Determination Review Form.	10-14-15	To be completed within 30 days of client episode opening or notification of an open Child Welfare Services case.
Progress Report to Child Welfare Services	5-21-15	To be submitted to CWS at intake, quarterly, and at discharge.
Child and Family Teaming Standards	7-23-14	Provide copies to the members of the Child and Family Team (CFT) after the initial CFT meeting.
Progress Summary and Action Plan	7-23-14	Provide copies to the members of the Child and Family Team after each CFT meeting.
Individual Progress Note/ ICC Note	11-09-16	When used to document CFT meetings, offer copy to youth, caregiver, and PSW.

Pathways to Well-Being Program

Behavioral Health Services Pathways to Well-Being program staff are available to provide technical assistance to providers in all aspects of the implementation of Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) in accordance with the Core Practice Model. The Pathways to Well-Being team can be reached through the BHETA website link below under section "Contact Us".

Resources

The California Department of Health Care Services (DHCS) Medi-Cal Manual provides guidelines for delivering and billing ICC and IHBS:
http://www.dhcs.ca.gov/services/Documents/Medi-cal_manual_9-22-16.pdf

The California DHCS Core Practice Model Guide reflects shared values and principles:

http://www.dhcs.ca.gov/Documents/KACorePracticeModelGuideFINAL3-1-13.pdf

Forms referenced above are located on the **BHETA Pathways to Well-Being** website. The page includes general information, required forms, training, schedules, and contact information for BHS and CWS Pathways to Well-Being staff:
http://theacademy.sdsu.edu/programs/BHETA/pathways.html

Documentation Manual can be found on the Optum Website:
https://www.optumsandiego.com/content/sandiego/en/county-staff---providers/orgpublicdocs.html

QI PROGRAM MONITORING

The BHS Quality Improvement Unit shall monitor each organizational provider and county operated program for compliance with these requirements, to assure that activities are conducted in accordance with both State and MHP standards. If the delegated entity's activities are found not to be in compliance, the MHP shall require that a corrective action plan be formulated. Progress toward change will be effected through direct management in the case of a County operated program, or through contract monitoring in the case of a contractor. The Quality Improvement Unit will prioritize and discuss opportunities for improvement with any provider having performance problems. Corrective action plans shall be monitored for implementation and appropriateness as deemed necessary, between annual reviews. If the provider does not successfully correct the problems within the stated timeframe, the County will take appropriate remedial action.

Financial Eligibility and Billing Procedures

Each provider is responsible for specific functions related to determining client financial eligibility, billing and collections.
The *Organizational Provider Financial Eligibility and Billing Procedures Handbook* (listed as "*Financial and Eligibility User Manual"* at https://www.Optumsandiego.com) is provided by CYFS for providers as a guide for determining financial eligibility, billing and collection procedures. This handbook includes the following procedure categories:

- Using the MIS.
- Adding a new client.
- Assignment opening/closing and service entry.
- Determining financial eligibility.
- Claims, billing, and posting procedures.
- Training and technical assistance.

PROVIDING SPECIALTY MENTAL HEALTH SERVICES

This handbook is not intended to replace the *Management Information System CCBH User*'s *Manual* (https://www.Optumsandiego.com) or intended to be a comprehensive "Insurance and Medi-Cal Billing" guide. It is meant to augment existing resource materials.

These are "living" handbook/manuals that are revised as new processes/procedures are implemented.