D. PROVIDING SPECIALTY MENTAL HEALTH SERVICES

ADULT/OLDER ADULT SYSTEM OF CARE

Coordination of Care: Creating a Seamless System of Care

Coordination of care between service providers is essential for a client's continuity of care and a mental health system to work efficiently. As a client may move between different levels of care, it is vital that service providers complete a **warm hand off** with each other to provide continuity of care for the client. This is accomplished in the following manner: Providers shall develop discharge planning to support individuals transitioning between the same or a different level of care, including those outside the BHS system of care. This includes but is not limited to the referring provider making contact with, and developing collaborative communication with *one individual staff member* responsible for intake at the receiving provider, transportation to the receiving provider, and participation in appointment fulfillment or confirmation/documentation of receiving provider achieving a face-to face linkage. 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 assign each client a care coordinator as the "single point of accountability" for his or her rehabilitation and recovery planning, through 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.

Clients diagnosed with a primary or co-occurring opioid and/or alcohol use disorder should be offered a referral for an assessment for Medication Assisted Treatment (MAT). Although it is outside the scope of practice for a non-prescribing staff to make specific medication recommendations, staff can recommend a referral for MAT at the intake appointment and at other points in the treatment process, as clinically indicated. Staff are encouraged to use motivational interviewing to help clients who would benefit from medication treatment to consider this option. Clients with an opioid and/or stimulant use disorder should be referred or linked to naloxone treatment to prevent overdose risk.

Program Policy and Procedures should address clinical training and supervision on providing appropriate MAT referrals as clinically indicated at any time during treatment or following an overdose. This training and supervision should also address access to Naloxone, especially for clients who refuse a MAT referral and have an opioid use disorder.

Post Discharge Coordination of Care

New or current clients discharged from a 24-hour facility (acute psychiatric hospital or crisis house) shall be assessed by program within 72 hours. If after assessment, the client is deemed urgent, client shall be seen within 48 hours of contact with program. 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. Compliance to this standard is monitored through the Medical Record Review process.

Outpatient, Case Management and Assertive Community Treatment 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, Case Management, Assertive Community Treatment 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 CASE MANAGEMENT AND ASSERTIVE COMMUNITY TREATMENT SERVICES

Brief Description of Services Available

San Diego County Adult/Older Adult Behavioral Health Services are as follows:

- Transitional Case Management provides short-term case management services (up to 90 days) for unconnected clients who suffer from severe mental illness (SMI) and are discharged from Acute Care (ex: Behavioral Health unit (BHU). The goal is to connect clients to outpatient case management and/or Assertive Community Services as clinically indicated.

- Institutional Case Management services are provided to clients who reside in a 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 1:60. Clients are contacted face to face at a minimum of once a quarter

- Strengths-Based Case Management (SBCM) programs are only authorized to provide case management brokerage, individual and group rehabilitation, collateral, and occasional crisis intervention services. SBCM services provide a mix of mental health, rehabilitation and case management functions and have a staff-to-client ration of approximately 1:25. Clients are typically evaluated in person at a minimum of once a month. Services may be provided on a much more frequent basis, depending on client clinical need. It is also expected that the case manager will have contact with significant others as clinically appropriate.

- 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 only if it is done by an SBCM program run by the County of San Diego.

Case Management evaluations done by contractors should be coded as an Assessment. Assertive Community Treatment (ACT) programs are authorized to provide primarily case management brokerage and individual and group rehabilitation, collateral and occasional crisis intervention services. The services provided are a mix of medication, mental health, rehabilitation and case management functions and have a staff-to-client ration of approximately 1:10. Clients are typically evaluated in person at a minimum of four (4) times per week in order to meet the client's clinical needs and meet a high ACT fidelity rating. ACT programs are also authorized to provide an initial clinical assessment for the purposes of determining medical necessity, medication support services and some psychotherapy.

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. Within one month after program assignment, an Assessment and Client Plan shall be completed for clients in community setting.

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

Strength-Based Case Management

Strengths-Based Case Management services are delivered through BHS contracted service. Programs assist clients with severe mental illness who may have a co-occurring disorder and may be justice-involved to access needed mental health, medical, educational, social, prevocational, vocational, housing supports and rehabilitative or other community services. The service activities may include, but are not limited to case management, care coordination, referral and linkage to needed services; monitoring services delivery to ensure beneficiary access to services and the services delivery system, monitoring of the client's progress, and plan development. The SBCM model emphasis is on the structure of the program, supervision and clinical services. The staff ratio is approximately 1:25.

Eligibility Criteria: Client must meet two or more of the criteria below

- Medical Necessity must be established (face to face) to determine the presence of a severe psychiatric disability and need for Strength Based Case Management (SBCM) services per LOCUS (Level 3 – High Intensity Community Based Services)

- Has current LPS Conservatorship (may be a designated County Conservator or family member (Private Conservator);
- Client is not homeless but may be at-risk of homelessness
- Minimum one hospitalization in the past year, OR multiple ER utilizations, PERT interventions, jail mental health service and/or long-term care hospitalization.
- Have major impairments in life functioning
- Person is not connected to outpatient treatment
- Person is experiencing an acute psychiatric episode that might require SBCM level services
- 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

Services provided include, but are not limited to:

- Medication management which is coordinated outside the SBCM program in the FFS sector
- Strength Based Case Management
- Rehabilitation and recovery services
- Care Coordination to needed services
- Co-occurring services linkages
- Access and linkage to Supportive Housing
- Access to Supportive employment/vocational and educational services

- **Discharge Criteria**:

  - The goal of SBCM is to help improve the clients' mental health and quality of life to support clients to live in the least restrictive environment. A LOCUS is completed every 6 months to assist in determining if client is ready for lower level of care. Clients receiving Strength-Based 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 level of case management.

Assertive Community Treatment (ACT) Services

ACT Services are provided in a multi-disciplinary team-based model of service that uses a comprehensive team approach and provides treatment 24 hours a day, 7 days a week, 365-days a

year. The services are targeted for **homeless** persons with a severe mental illness who may have a co-occurring disorder, are unconnected to outpatient services, may be referred by the justice system, have multiple major areas of impairment, have more than one long term care episode, and multiple ER and acute care hospitalizations and justice related episodes.

The ACT programs provide **integrated** mental health and medication services, rehabilitation and recovery services, intensive case management and has a staff-to-client ratio of approximately 1:10. Clients are typically provided services in person at a minimum of four (4) times per week to meet ACT fidelity rating and the appropriate clinic need of the client Services may be provided on a much more frequent basis, depending on client need.

Eligibility Criteria:

- Same as SBCM plus
- Homelessness or at risk of homelessness
- Level of acuity and need for intensive ACT services per LOCUS assessment (Level 4 – Medically Monitored Non-Residential Services)

Services provided include, but are not limited to:

- Integrated Mental Health Services and Medication Management
- Rehabilitation and recovery services
- Intensive case management
- Co-occurring services
- Access and linkage to Supportive housing
- Access to Supportive employment/vocational and educational services
- Care Coordination to needed providers

- **Discharge Criteria**:
  - Same as SBCM

CLINICAL STRENGTH-BASED CASE MANAGEMENT (SBCM) AND ASSERTIVE COMMUNITY TREATMENT (ACT) SERVICES COORDINATION WITH PUBLIC CONSERVATOR – ADULT AND OLDER ADULT MENTAL HEALTH SERVICES

Overview

For Contractors and County Case Management who provide clinical SBCM and/or ACT Services to LPS Conservatees on behalf of the Public Conservator, responsibilities include:

Ensure active and continuous clinical Strength-Based Case Management and/or Assertive Community Treatment Services responsibility, which includes, but is not limited to, ensuring the Conservatee has appropriate:

- Medical care and treatment
- Psychiatric care and treatment
- Personal care
- Food/Nutrition
- Clothing
- Shelter
- Education and employment
- Recreation and socialization

2. Ensure a clear photograph of the conservatee is taken at the initial face-to-face visit and annually thereafter. The photo must be preserved in the case file for the purpose of identifying the conservatee if he or she becomes missing (per Probate Code 2360)

3. Collaborate/Coordinate with medical and psychiatric professionals and hospital treatment teams on behalf of the conservatee.

4. Notify all appropriate parties, including family members and other significant parties, of the assigned Case Manager or Case Management team within 14 calendar days (see item #10 below for notification requirements for the Public Conservator's Office)

5. Respond to routine e-mails and phone calls within 2 business days; for more urgent matters, a Supervisor/Program Manager should be available if parties are unable to reach the Case Manager.

6. Upon request, provide case information to the Public Conservator's Office regarding grave disability, including information on the following:

   a. Clinical presentation (psychiatric/medical, functional ability, etc.)
   b. High-risk behaviors
   c. Activities of daily living
   d. Current medications and adherence
   e. Placement history
   f. Strengths and goals

7. Maintain documentation regarding visits for viewing by Public Conservator Office staff.

8. Ensure conservatee has both a psychiatrist and a primary care physician who will prepare (by a psychiatrist/psychologist) and concur with (by a primary care physician) the annually required Medical Recommendation and Declaration to Reestablish Conservatorship (see Optum Website OPOH Tab: Reestablishment Recommendation Form) (HHSA LPS PC RE-EST). This form must be prepared/signed by both of the conservatee's physicians and submitted to the Public Conservator's Office at least 45 days prior to the end date of the current conservatorship period, which communicates their recommendation as to either the reestablishment or termination of LPS conservatorship. The case management agency must ensure the conservatee is able to see both the psychiatrist and a primary care physician 2 to 4 months prior to the end date of the current conservatorship period. The names and telephone numbers of these physicians must be provided to the Public Conservator's Office and should be kept current in Cerner.

9. Maintain involuntary clinical Strength Based Case Management and/or Assertive Community Treatment Services at all times while a conservatorship is in place. If the conservatee is being transferred to another Case Management Agency, services of the sending agency must be maintained until verification is received that the conservatee has been contacted and is prepared to receive involuntary case management services from the receiving agency. The receiving agency must notify the Public Conservator's Office of the successful transfer and start of services with the receiving agency. Services may only be provided on a voluntary basis (or closed) if the Public Conservator's Office has indicated the conservatorship has been terminated by the court.

10. Notify the Public Conservator's Office within 24 hours when any of the following situations occur for a conservatee:

    - Address changes
    - A new case manager is assigned
    - A new case management agency has been assigned
    - AWOL or in a missing person status
    - Hospitalization (medical and/or psychiatric)

- In custody
- Death
- A Serious Incident Report is submitted to the BHS Quality Improvement Unit
- Any unusual occurrences that raise risk/safety concerns

11. Notify Public Conservator's Office in writing when it is believed a change in rights or when it is believed the Conservatee is no longer gravely disabled.

12. Refer treatment providers to the Public Conservator's Office for matters requiring the consent of the Court via the Public Conservator's Office, such as surgery, non-routine medical treatment or end of life decisions.

13. Contact the Public Conservator's Office when questions arise regarding the Conservatee's desire/need to enter into contracts of any kind, obtain a driver's license, vote or participate in a research study.

14. Contact the Public Conservator's Office when there is a need to have documents signed on behalf of the Conservatee, except in cases involving assistance with Social Security and Medi-Cal applications, renewals, redeterminations, appeals, etc.

15. Ensure a report is available via the electronic health record (EHR) for the Public Conservator's Office to view monthly, including completed visits.

Initial Face-to-Face Visits

Initial Face-to-Face visits with conservatees will be conducted according to the type of case management program provided, as follows:

1. **ACT**: within 48 hours of the program formally opening the case, consistent with the OPOH standard for face-to-face visits for those deemed urgent and recently discharged from acute care

2. **SBCM**: 10 business days of the program formally opening the case, unless deemed urgent and recently discharged from acute care which would then require the urgent visit within 48 hours

3. **Institutional-In County**: within 30 days of the program formally opening the case or expedited in response to clinical need, on a case-by-case basis

4. **Institutional-Out of County**: within 90 days of the program formally opening the case or expedited in response to clinical need, on a case-by-case basis

5. **Hospital Rotation Cases**: The Public Conservator's Office has case management responsibilities during the Temporary LPS Conservatorship. During this time Strength-Based Case Management and/or Assertive Community Treatment programs will not be responsible for face-to-face visits or discharge planning, as this will remain the responsibility of the Public Conservator. Once Permanent Conservatorship is established, as long as patient remains in acute care, the case will be opened to County Institutional Case Management services pending discharge to either long-term care or community placement.

    a) **If discharge is imminent** (planned in less than 10 business days) when the case is opened to County Institutional Case Management services, no face-to-face contact must be made unless the client is requesting such contact, or it is otherwise clinically indicated. Telephone contacts may be made as needed to facilitate discharge planning or other clinical needs during the time the patient remains in acute care.
    b) **If discharge is not imminent** at the time the case is opened to County Institutional Case Management services, the case manager must plan to meet with the patient in the acute care setting within 10 business days of case opening, with the exception of patients in jail settings.
    c) **For conservatees in jail settings** (where discharge is not imminent at the time Permanent Conservatorship is established), face-to-face contact must be made within 30 days of opening case to County Institutional Case Management to accommodate clearances needed and access to incarcerated individuals.

6. When a **Private Conservator** is appointed and requests the assistance of County operated Case Management Services, initial face-to-face contacts will follow the same periods as when the Public Conservator is appointed.

<u>On-Going Face-to-Face Visits</u>

Frequency of visitation will be conducted according to either Strength-Based Case Management (SBCM) or Assertive Community Treatment (ACT) program as follows:

1. SBCM: Clients are typically seen in person at a minimum of once a month. Services may be provided on a much more frequent basis, depending on client clinical need. It is also

expected that the case manager will have contact with significant others as clinically appropriate.

2. ACT: Clients are typically evaluated in person at a minimum of four (4) times per week in order to meet the client's clinical needs and meet a high ACT fidelity rating. It is also expected that the case manager will have contact with significant others as clinically appropriate.
3. Institutional-In County: routine visits to occur every 90 days. Frequency to increase based on clinical need on a case by case basis
4. Institutional-Out of County: visits to occur every 90 days. Phone contacts to occur monthly in between face-to-face visits. Frequency of visits to increase based on clinical need on a case-by-case basis

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 of 60 and above on the ASP scoring tool – if below a score of 60 will need Behavioral Health Program Coordinator (BHPC) approval; 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.

Peer Led Interventions

Peer Led Interventions provide an additional tool to assist clients in developing self-awareness and self-mastery skills. Those providing this service can be peer specialist, individuals with "lived experience" or family members of consumers. Examples of peer led interventions include but are not limited to Wellness Recovery Action Plan® and Whole Health Action Plan (WHAM). These services are designed to assist clients in managing day to day activities in at home and in the community. Designated staff with an understanding of the peer experience may also facilitate the structured interventions.

Telehealth Services

Each telehealth provider is required to be licensed in California and enrolled as a Medi-Cal provider. If the provider is not located in California, they must be affiliated with an enrolled Medi-Cal provider group (or border community) as indicated in the Medi-Cal Provider Manual. Each telehealth provider must meet the requirements of BPC Section 2290.5(a)(3), or equivalent requirements under California law in which the provider is licensed.

Existing Medi-Cal covered services may be provided via telehealth modality if all the following criteria are met:

- The treating health care provider at the distant site believes the services being provided are clinically appropriate to be delivered via telehealth based upon evidence-based medicine and/or best clinical judgment;
- The member has provided verbal or written consent;
- The presence of a health care provider is not required at the originating site unless determined medically necessary by the provider at the distant site;
- The medical record documentation substantiates the services delivered via telehealth meet the procedural definition and components associated with the covered service; and
- The services provided via telehealth meet all laws regarding confidentiality of health care information and a patient's right to the patient's own medical information.

Medi-Cal providers have the flexibility to determine if a service is clinically appropriate for telehealth via audio-visual two-way real time communication. No limitations are placed on origination or distant sites. Providers must use the applicable billing indicators for services delivered via telehealth.

Videoconferencing Guidelines for Telepsychiatry

Telepsychiatry services are designed to assure timely access of urgent psychiatric services to reduce emergency and acute clients' hospital inpatient services Psychiatrists or Nurse Practitioners (NP); hereafter referred to as "telepsychiatry prescriber" will perform various psychiatric services via tele-video linkage when an on-site Psychiatrist or NP is unavailable; primarily due to illness or other scheduled absences or vacancies; or other special needs as arranged. The site where the telepsychiatry prescriber is located who will provide the mental health service will be termed "distant" site and the site where the mental health services are being received by the client will be termed the "originating" site. This practice also extends psychiatric services to clients in remote areas of the county.

The standards of telepsychiatric practice will be the same as for on-site psychiatric services as described in the California "Telehealth Law of 2012".

County contracted organizational providers connecting to their own network must follow the guidelines below in order to deliver secure telepsychiatry services.

- Use a secure, trusted platform for videoconferencing.

- Verify your devices and software use the latest security patches and updates. Install the latest antivirus, anti-malware, and firewall software to your devices. The underlying network must provide security.

- Verify your device uses security features such as passphrases and two-factor authentication. Your device preferably will not store any patient data locally, but if it must, it should be encrypted.

- Verify your audio and video transmission is encrypted. The Federal Information Processing Standard (FIPS) 140-2 is used by the United States government to accredit encryption standards. Encryption strengths and types can change. When partnering with 3rd party telepsychiatry vendors, verify if their encryption meets the FIPS 140-2 certified 256 bit standard; that any peer-to-peer videoconferencing (streamed endpoint-to-endpoint) is not stored or intercepted by the company in any way; and that any recorded videoconferences or—if available—text-based chat sessions near the chat window are stored locally, on your own HIPAA-compliant device or electronic record keeping system, in order to safeguard any electronic protected health information or PHI.

- Choose a software solution that is HIPAA-compliant, as many popular, free products are not. Compliance with HIPAA (Health Insurance Portability and Accountability Act of

1996) is essential. HIPAA sets a minimum federal standard for the security of health information. States may also set privacy laws that can be even more strict, so be sure to check any relevant statute for the state in which you practice. Just because software says its HIPAA-compliant isn't enough. HIPAA compliance may also be dependent on the interface of your videoconferencing software with other aspects of your practice, such as EHRs, so it is best to think about HIPAA and telepsychiatry from a global, "all technologies" perspective.

- It is recommended to use a broadband internet connection that, at minimum, has a transmission speed of at least 5 MB upload/download to avoid pixilation, frequent buffering, and other video and audio difficulties associated with slow and insufficient transmission. Higher speeds might be required for newer technologies that use HD capabilities.

When reviewing software options, you will notice that many vendors require a "business associate agreement," or a BAA, to ensure HIPAA compliance. Contact the vendor and confirm what such an agreement entails.
County operated programs shall connect to the County's secure network when providing telepsychiatry services as the network meets the above requirements and is a trusted platform for videoconferencing. Hardware shall be installed by the County's IT department.

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.

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

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.

- Hospitals cannot require as a condition of admission or acceptance of a transfer that a patient voluntarily seeking mental health care first be placed on a 5150 hold.

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

1. Continued presence of indications that meet the medical necessity criteria
2. Serious adverse reaction to medications, procedures or therapist requiring continued hospitalization
3. Presence of new indications that meet medical necessity criteria; and,
4. Need for continued medical evaluation or treatment that can only be provided if the beneficiary remains in the hospital

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 but do require initial authorization from Optum. Optum will then reauthorize medically necessary services, as appropriate, concurrently with the client's stay based on the continued need for services. More information about the locations and services provided by the Crisis Residential Programs may be obtained from the contractor's website, Community Research Foundation (www.comresearch.org). The Optum Provider Line for authorization is 1-800-798-2254.

If a request for authorization is considered to be incomplete, the request will be withdrawn. Optum will notify the provider of the incomplete submission and request that the provider resubmit with

additional clinical information. Without a complete authorization request, determination to approve or deny authorization cannot be made. Without authorization approval services may not be billable.

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. Due to the passage of SB 389, MHSA funds may be used to provide services to persons who meet existing eligibility criteria for MHSA-funded programs and who are participating

in a pre-sentencing or post-sentencing diversion program, to provide services to persons who are on parole, probation, PRCS, or mandatory supervision. When included in county plans, and in accordance with all the requirements outlined in W&I § 5349, funds may be used for the provision of mental health services in an Assisted Outpatient Treatment program in counties that elect to participate in the Assisted Outpatient Treatment Demonstration Project Act of 2002 (Article 9 (commencing with Section 5345) of Chapter 2 of Part 1). Additionally, MHSA may be used for programs and/or services provided in juvenile halls and/or county jails when the purpose of the service is facilitating discharge (CCR, Title 9, § 3610).

7. MHSA funded services are **not** available for individuals incarcerated in state or federal prisons (W&I § 5813.5(f); CCR, tit. 9, § 3610, subd. (f)).

Correctional Program Checklist (CPC)

As directed by COR, contractor will fully participate in the Corrections Program Checklist (CPC) to improve treatment quality for clients who are assessed to be moderate to high risk for recidivism. Additional information regarding the CPC is located on the Optum Website:

https://www.optumsandiego.com/content/sandiego/en/county-staff---providers/orgpublicdocs.html

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.

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 justify medical necessity and obtain authorization for continued services concurrently with the client's stay. 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. 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
- 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.

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.

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.

This criterion 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 Utilization Management Form documenting justification for 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.
f. Client is actively using substances.

IV. Utilization Management process for Outpatient Programs:

Clients shall meet specific criteria and be reviewed through a Utilization Management (UM) process which shall be conducted internally by a Utilization Review Committee (URC) at all County and county contracted outpatient clinics.

- **Provision of services shall be reviewed for clients based on follow criteria:**

1. MORS rating of 6 or higher must go through Utilization Management
   a. Clients with a MORS rating of 6 to 8 will be referred out of the County or County contracted outpatient clinic for ongoing services unless an exception is made (see exception noted below).
   b. If a client receives a MORS rating of 6 to 8 but the primary provider believes that the client should continue to receive services at the county or contracted outpatient clinic the primary provider may request Utilization Review Committee (URC) to review client's case and justify ongoing services if applicable. [Note that someone with a MORS rating of 8 would probably be better supported at a lower level of care.]

- **While not required, the provision of services may be reviewed for clients based on one or more of the follow criteria:**

2. Clients with unchanged MORS rating
3. Clients who have been enrolled in program services for 2 years or longer
4. Treatment Team recommendation.
   a. URC may review client's that meet the above criterion in order to determine appropriateness for ongoing services or transition to a lower level of care.

- **For continued authorization of ongoing services, the following criteria must also be met:**

   a. Continued Medical Necessity with demonstrated benefit from services.
   b. Meet Target Population Criteria.

Utilization Review Committee (URC)

Programs are required to have an internal URC in place to review records and conduct UM process. URC shall follow the guidelines below:

a. Review quarterly a minimum of 5 clients.
b. A review of services, treatment plan, and the Utilization Management Form shall be completed in order to support determination and document the results of the Utilization Review Committee.
c. Client service review shall be performed through CCBH *Client Services Report*. [Note that clients who have not received services for six months or longer should be considered for discharge.]
d. Utilization Management Form shall be reviewed by program manager or designee within 5 business days.
e. Program manager or designee shall be licensed.
f. Program manager or designee may agree with primary provider or may recommend a different level of service.
g. Final determination shall be made after agreement by program manager or designee and primary provider.
h. The Utilization Management Form shall be kept in the client record.
i. At the time of your Medical Record Review, QM Specialists will review client Utilization Management Forms in addition to programs quarterly URC process.

Clients who have been approved for ongoing services by the URC shall remain on an UM cycle to be completed annually in order to determine continued eligibility for services.

V. Outcome Measures

The following outcome measures shall be employed in order to inform the Utilization Management process. These measures are completed at assessment (within 30 days of admission) and every 6 months thereafter by all County and County contracted outpatient providers.

1. **Recovery Markers Questionnaire (RMQ)**
2. **Illness Management and Recovery (IMR)**
3. **Milestones of Recovery Scale (MORS)**
   a. Clients with a MORS rating of 1 to 5 will be qualified to receive ongoing services at the County or Contracted outpatient clinic.
   b. The MORS rating shall be kept in the client record

Time spent with the client completing outcome measures may be claimed as part of another

direct client service when the information obtained from the outcome measure is used for UM/UR review. Documentation shall demonstrate how the information was used for furthering the clinical assessment or for planning, guiding or developing treatment.

Utilization Review for ACT/FSP/Case Management Programs

Each ACT, FSP, and 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 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 *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* 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.

AOA and CYF Missed Appointment and Follow Up Standard

County of San Diego MHP has adopted a SOC average "No Show" rate for both licensed/registered/waivered clinicians and psychiatrists. The SOC average "No Show" rate is 15% for licensed/registered/waivered clinicians and 20% for psychiatrists. As data is collected, the County will continue to evaluate the SOC average "No Show" rates and consider adjustments to standards as necessary. Missed Appointment 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 (defined as a "No Show"). The client shall 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 (defined as a "No Show"). The client shall 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 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 providers shall have policies and procedures in place regarding the monitoring of missed appointments for clients (and/or caregivers, if applicable).

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

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**
Non-Complex calling for medical intervention	Primary Care Physician (PCP) Medical Home Health Plans	TBD by medical team	
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
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 Medi-Cal Specialty Mental Health Services: For children and youth up to age 21, a lower threshold of severity as defined by EPSDT is applied.

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 Delivery System Notice **NOABD-** (which must also be documented in the **NOABD Log**)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 ensuring 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 Needs and Strengths (CANS), Pediatric Symptom Checklist (PSC) and Youth Services Survey (YSS).

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.

INTENSIVE SERVICES

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. Program design promotes a therapeutic milieu which is 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.

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. Program design promotes a therapeutic milieu which is 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.

Day School Services – an intensive outpatient program that includes a full range of short-term Title 9 specialty mental health services including assessment, evaluation, plan development, collateral, individual/group/family therapy, rehabilitation, Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), crisis intervention, and case management services. These services are provided to children and youth identified through an IEP or school district process as needing a Special Education Classroom setting to be successful in school. Services are intensive and flexible to meet the needs of the client and assist in transitioning to a less restrictive classroom setting.

Residential OP – an intensive outpatient program within a residential milieu that includes a full range of short-term Title 9 specialty mental health services including assessment, evaluation, plan development, collateral, individual/group/family therapy, rehabilitation, Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), crisis intervention, and case management services. These services are provided in a group home facility/ Short-Term Residential Therapeutic Program (STRTP). Services are intensive and flexible to meet the needs of the client and assist in transitioning to a less restrictive, community based or family care setting.

Authorization Process for Intensive Services

(Day Treatment Intensive, Day Rehab, Day School Services and Residential OP Services)

Prior to admission to the program, each client must have

- a face-to-face assessment to establish medical necessity,
- an assessment that documents a recommendation for applicable level of care (day or outpatient),

- documentation that lower levels of care have been tried unsuccessfully or would be unsuccessful if attempted,
- documentation that highly structured mental health program is needed to prevent admission to a more intensive level of care.

The initial Day Service Request (ISR) is to be completed and submitted to Optum prior to the provision of services and re-authorized every 3 months (for Day Treatment Intensive, Day School Services, and Residential OP) or 6 months (for Day Rehab), depending on the service being requested. For continuing authorization requests, the DSR form is submitted to Optum at least 15 calendar days before the previous authorization expires. The Day Service Request (DSR) form is located on the Optum Website under UCRM tab.

The Day Service Request essentially states that the client cannot be served at a lower level of care and that a recommendation for intensive services has been made. If medical or service necessity criteria are not met, the Medi-Cal client will be issued an NOABD (which must also be documented in the NOABD log) and the beneficiary rights shall be explained. In the event that the provider has received a denial of authorization from Optum, a NOABD shall be issued by Optum.

Day Service Request (ISR) Information

- Prior authorization must be submitted prior to the opening of the assignment or the provision of services. The Optum Provider Line for authorization requests is 1-800-798-2254. The required authorization request forms are located on the Optum Website under BHS Provider Resources Tab via this link: MHP Provider Documents
- All clients receiving services in Day Rehab, Day Treatment Intensive, Day School Services (DSS), or Residential Outpatient (OP) will require a Day Service Request.
- Authorization cycles are based on months and not days (i.e. for Day Treatment Intensive an authorization cycle may look like: Initial Day Service Request (DSR) 1/1/08-3/31/08 and Continued DSR 4/1/08-6/30/08. For Day Rehabilitation Day Service Request (DSR) 1/1/08- 6/31/08, Continued DSR 7/1/08 – 12/31/08, etc.).
- Optum will review the DSR and determine authorization within 5 business days. The provider may contact Optum if there are questions. The signature page of the DSR will be faxed back to the program upon authorization.
- Authorization will include intensive services and, when applicable, ancillary services for each client. Authorizations for intensive and ancillary services are entered separately based on the timeline of the receipt of the request by Optum.
- It is the responsibility of each program to determine insurance coverage (or lack of) in order to decide which process to follow:
    - DSRs 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)
    - DSRs 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)
- 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.
- DSRs 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 DSR 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 DSR Ancillary information is done incorrectly, Optum will send the DSR to the Day program with whom the outpatient program is coordinating.
- Questions regarding the DSR process may be directed to: Optum at (800) 798-2254 option #4.

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

Utilization Review

Utilization review of day treatment intensive, day rehabilitation, day school services, and residential outpatient services for Medi-Cal clients is delegated to Optum.

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

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. Assembly Bill (AB) 1299 and Senate Bill (SB) 785 intend to improve the timely access to services.

AB 1299 for Foster Youth: Establishes the presumptive transfer of responsibility and payment for providing or arranging mental health services to foster children from the county of original jurisdiction (placing county) to the foster child's county of residence.
MHSUDS Information Notice No. 17-032 (Dated 7/14/17)

SB 785 for AAP and KinGAP: Transfers 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 (Dated 8/13/08 and 5/4/09)

Program Procedure(s) for Medi-Cal Eligible Children in Foster Care under AB1299: For foster children whose care is presumptively transferred to San Diego

1. Placing agency from the county of origin may instruct 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 placing agency informs Optum of the presumptive transfer.
3. The program providing the services submits the Service Authorization Request (SAR*)* to the county of origin MHP **as a notification**. The service provider shall begin to provide services once the notification is sent and is not required to wait until receiving the signed SAR from the county of origin.

4. If requested by the placing agency of the county of origin, the program will inform them of the services being provided, in accordance with the privacy standards contained in the Health Insurance Portability and Accountability Act (HIPAA) and Medi-Cal confidentiality requirements.
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. Intensive Service programs shall submit the notification SAR and the ISR to Optum.
8. Residential programs shall complete an AB1299 Admission and AB1299 Monthly Summary Report submitted to the COR by the 15th day of the following month.

Program Procedure(s) for Medi-Cal Eligible Children in AAP/KinGap under SB 785:

1. Placing agency from the county of origin may instruct 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. For outpatient services, 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. If requested by the placing agency of the county of origin, the program will inform them of the services being provided, in accordance with the privacy standards contained in the Health Insurance Portability and Accountability Act (HIPAA) and Medi-Cal confidentiality requirements.
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. Intensive Service programs shall submit the notification SAR and the ISR to Optum.
8. Residential programs shall contact the COR for prior authorization for admission and confirm that out-of-county youth has a San Diego connection/caregiver.
9. Residential programs shall complete an AB1299 Admission and AB1299 Monthly Summary Report submitted to the COR by the 15th day of the following month which includes information about out of county KinGAP and AAP youth.

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). For those clients the program shall submit a SAR to the Mental Health Plan (MHP) from the County

of Jurisdiction. The clients are subject to our local UM process and the services are entered into our MIS/CCBH.

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 programs to serve them. Programs need to get authorization from COR to serve those kids prior to Medi-Cal shifting to San Diego. When 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.

Therapeutic Behavioral Services (TBS)

Prior authorization through Optum is required preceding the provision of Therapeutic Behavioral Services (TBS). Clients are referred to New Alternatives, Inc. (NA), who is the point of contact for TBS. The referring party may include COSD SOC, CWS and Probation Department. The referring party will complete and return an authorization request form and to the Administrative Services Organization (ASO) who provides authorization for TBS. Optum acts as the ASO. Authorization requests are then screened and assessed by Optum UM licensed clinicians for eligibility criteria according to California Department of Mental Health guidelines provided in DMH Letter 99-03 and DMH Notice 08-38. Optum UM licensed clinicians will then send authorization response to the referring party within 5 business days of receipt of request. The provider assigned to the client/family will conduct an assessment to ensure the client meets the class, service, and other TBS criteria prior to services being delivered.

Prior authorization must be submitted prior to the opening of the assignment or the provision of services. The Optum Provider Line for authorization requests is 1-800-798-2254. The required authorization request forms are located on the Optum Website under BHS Provider Resources Tab via this link: MHP Provider Documents

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

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 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,** which include information about accessing Therapeutic Behavioral Services (TBS) 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.

https://www.dhcs.ca.gov/formsandpubs/forms/Forms/MCED/Info_Notice/MC003_ENG.pdf
https://www.dhcs.ca.gov/formsandpubs/forms/Forms/MCED/Info_Notice/MC003_SPA.pdf

Pathways to Well-Being and Continuum of Care Reform

Overview

Pathways to Well-Being (PWB) was prompted by the Katie A. class action lawsuit, 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 lawsuit 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 the lawsuit in December 2011, and in March 2013, issued the Core Practice Model (CPM) Guide. In May 2018, the CPM was revised and renamed the Integrated Core Practice Manual (ICPM) and

provides practical guidance and direction to support county child welfare, juvenile probation, behavioral health and partners in the delivery of timely, effective, and collaborative services.

PWB 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 and Youth/Family Support Partners. 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 establish long term permanency within a home-like setting. PWB 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.

PWB 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.

California's Continuum of Care Reform

California's Continuum of Care Reform (CCR) builds on the efforts made through the Katie A. class action suit. CCR is mandated through AB403 (2015) and AB1997 (2016) and integrates the positive practices identified through the implementation of PWB. CCR strives to help all children live with permanent, nurturing and committed families, and to reduce the time children spend living in congregate care. CCR adheres to fundamental principles including youth and family receiving collaborative and comprehensive supports through teaming and youth not having to change placement in order to get services and support. CWS and Probation have mandated timelines for CCR, Child and Family Team (CFT) meetings that include specific case decision making situations such as**:**

- Court hearing schedules
- Placement changes
- Child removed from his or her home and a plan is needed for the youth and family
- Child is in out of home care and a change in placement is required or requested
- Child returning home
- Permanent plan for a child needs to be made

- Child/youth's mental health needs or placement in a group home should be assessed
- Any family member involved in a child's case requests to meet to talk about the child's placement or the family's service plan.

BHS providers will be invited to participate in CWS and/or Probation initiated CFT meetings in order to represent the youth's behavioral health treatment and needs. Whenever possible, CCR and PWB mandated CFT meetings shall be combined in order to create as few formalized meetings as necessary for the youth and family. It is the behavioral health provider's responsibility to ensure that behavioral health needs are discussed in the conjoint meetings.

Serving Youth with an Open Child Welfare Services Case

Upon intake and at each assessment interval, clients receiving mental health treatment 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 electronic Eligibility for Pathways to Well-Being and Enhanced Services form in Cerner Community Behavioral Health (CCBH) within 30 days of intake, at reassessment, at discharge and at noted changes throughout 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 Pathways to Well-Being Eligible (Class) or Eligible for Enhanced Services (Subclass). Youth who are identified as Pathways to Well-Being Eligible (Class), do not meet the eligibility criteria for Enhanced Services (Subclass), are not required to receive the services mentioned below, but are identified in CCBH in Client Categories Maintenance (CCM) as Class and ongoing collaboration between the provider and CWS will occur. The services below, though not required for youth that do not meet criteria for Enhanced Services (Class), are available to all Medi-Cal beneficiaries who meet criteria for Specialty Mental Health Services. (Form located at Responsive Integrated Health Solutions [RIHS] website, https://theacademy.sdsu.edu/programs/rihs/pathways/).

For all clients with an open CWS case, either Pathways to Well-Being Eligible (Class) or Eligible for Enhanced Services (Subclass):

- Identify in the Client Categories Maintenance (CCM) area of CCBH (aka "flip the switch") as either Class or Subclass.
- Submit the **Progress Report to Child Welfare Services** form to CWS (see secure region fax numbers on form) initially within 30 days of determining eligibility, any update (upon significant change or revised client plan), and at discharge. This form contains the client's diagnosis which the PSW may share with the courts. It is critical that the clinician inform

and prepare the child and caregiver regarding the nature of shared information for clients with an open CWS case.
(Form located at RIHS website: https://theacademy.sdsu.edu/programs/rihs/pathways/)

Eligible for 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 placement changes within 24 months due to behavioral health needs

or

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

If criteria 1 and 2 are met, but 3, 4, or 5 are not met, the youth will be considered Pathways to Well-Being Eligible (Class).

Child and Family Team

Under Pathways to Well-Being, all children entering the CWS system receive a mental health screening conducted by CWS 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 CFT and a CFT meeting. The CFT consists of people identified to ensure the youth has access to appropriate mental health and supportive services in order to promote safety, permanency, and well-being. The CFT meeting is just one way in which the team members communicate. The team composition is guided by the youth and family's needs and preferences. For youth **Eligible for Enhanced Services (Subclass), the initial CFT meeting must occur within 30 days of determining eligibility and follow up CFT meetings shall be conducted at a minimum of every 90 days.**

Following a CFT meeting, the CFT Meeting Facilitation Program is responsible for all members of the team receiving a copy of the **Child and Family Team Meeting Progress Summary and Action Plan** which includes specific action steps and timelines developed for the team members. If the provider has a COR-approved exemption from utilizing the CFT Meeting Facilitation Program, the BHS clinician is responsible for all members of the team receiving a copy

of the CFT Meeting Summary and Action Plan. The clinician also completes the **Child and Family Team Meeting Note** which focuses on the elements associated with CFT meetings and is utilized for documenting all CFT Meetings, including Wraparound CFT meetings. Additionally, clinicians will select **ID 92 Child Family Team** under Evidence Based Practice (EBP) button (Homework/CFT) for documenting the CFT meeting.

Forms are located at RIHS website in the Tools and Forms section:
https://theacademy.sdsu.edu/programs/rihs/pathways/

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

- Child/youth/TAY[M]
- Family/caregiver[M]
- CWS social worker[M]
- 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 are Eligible for Enhanced Services (Subclass) will have a Care Coordinator. BHS and CWS will work together to identify the Care Coordinator who 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, timelines and referrals to the CFT Meeting Facilitation Program. 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.

CFT Meeting Facilitation Program

All mental health treatment programs (other than those with a COR-approved exception) that serve youth and families who are participating in CFT meetings, are required to utilize the CFT Meeting Facilitation Program. The CFT Meeting Facilitation Program is responsible for scheduling, organizing and facilitating CFT meetings for children/youth up to 21 years of age, within the BHS Children, Youth and Families system of care who are receiving Intensive Care Coordination (ICC).

The program will also serve Child Welfare Services and Probation involved youth while closely collaborating and coordinating with all pertinent people in the youth and families life including CWS workers, Probation Officers, BHS providers, educational supports, other identified formal supports and natural supports. Providers will initiate the meeting process by completing the Child and Family Team Meeting Referral Form and faxing to the CFT Meeting Facilitation Program.

Intensive Care Coordination

Intensive Care Coordination (ICC) Service Code (SC) 82/882 is mandated for members of the Katie A Subclass and available through the EPSDT benefit to all children and youth under the age of 21 who are eligible for the full scope Medi-Cal services and who meet medical necessity for these services. ICC is provided through collaboration between the members of a CFT. **A Child and Family Team must be identified in order to provide ICC.** ICC requires active, integrated, and collaborative participation by the provider and at least one member of the CFT. ICC is a service that is used for the identification and coordination of ancillary supports and systems which promote safety, permanency, and well-being. ICC services are offered to clients with significant and complex functional impairment and/or whose treatment requires cross-agency collaboration. Examples of ICC include: facilitating or attending a collaborative team meeting or CFT 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. Other considerations for when to provide ICC are outlined in the California Department of Health Care Services (DHCS) Medi-Cal Manual, Second Edition (09/2016) as well as the DHCS Medi-Cal Manual Third Edition (01/2018). Both manuals provide guidelines for ICC, Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries. The Second Edition includes ICC provision considerations such as multiple mental health diagnosis, recent emergency room visits, and specifications related to the 0-5 population. The Third Edition includes how ICC differs from Targeted Case Management, a brief section on confidentiality and information sharing practices throughout the Child and Family teaming process, guidelines for when to convene a CFT Meeting, and provides more detailed information related to TFC. Additionally, it includes the updated notice stating that ICC may be billed when provided to Medi-Cal beneficiaries, under the age of 21, who are placed in group homes or Short Term Residential Therapeutic Programs (STRTP), if medically necessary. For more specific information, see link in the resources section for both editions of the Medi-Cal Manual.

Intensive Home-Based Services

Intensive Home-Based Services (IHBS) SC 83/883 are mental health rehabilitative services that are available to Katie A Subclass members as well as beneficiaries under 21 who are eligible for

the full scope of Medi-Cal services and meet medical necessity criteria and are receiving Intensive Care Coordination. Prior authorization through Optum is required preceding the provision of IHBS services. An authorization request form shall be completed and returned to the Administrative Services Organization (ASO) who provides authorization for IHBS. Optum acts as the ASO. Authorization requests are then screened and assessed by Optum UM licensed clinicians for eligibility criteria. Optum UM licensed clinicians will then send authorization determination to the requestor within 5 business days or receipt of request.

Prior authorization must be submitted prior to the opening of the assignment or the provision of services. The Optum Provider Line for authorization requests is 1-800-798-2254. The required authorization request forms are located on the Optum Website under BHS Provider Resources Tab via this link: MHP Provider Documents

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

Additionally, a Child and Family Team must be identified in order to provide IHBS. IHBS are individualized, strength-based interventions that assist the client in building skills necessary for successful functioning in the home and community. IHBS is offered to clients with significant and complex functional impairment. 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/or 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 are a lock out, including youth currently incarcerated and when the service is provided during day treatment hours, which is inclusive of these services. If a CFT meeting is provided during Day Treatment Intensive/Day Rehab hours, a CFT Meeting Note will be completed and the non-billable ICC (SC 882) will be utilized.

Therapeutic Foster Care

The Therapeutic Foster Care (TFC) service model allows for the provision of short-term, intensive, highly coordinated, trauma-informed and individualized Specialty Mental Health Service (SMHS) activities to children and youth up to 21 years of age who have complex emotional and behavioral needs and who are placed with trained, intensely supervised and supported TFC parents. Prior authorization through Optum is required preceding the provision of TFC services. An authorization request form shall be completed and returned to the Administrative Services Organization (ASO) who provides authorization for TFC. Optum acts as the ASO. Authorization requests are then screened and assessed by Optum UM licensed clinicians for eligibility criteria. Optum UM licensed clinicians will then send authorization determination to the requestor within 5 business days or receipt of request.

Prior authorization must be submitted prior to the opening of the assignment or the provision of services. The Optum Provider Line for authorization requests is 1-800-798-2254. The required authorization request forms are located on the Optum Website under BHS Provider Resources via this link: MHP Provider Documents

The TFC parent serves as a key participant in the therapeutic treatment process of the child or youth. The TFC parent will provide trauma-informed interventions that are medically necessary for the child or youth. The SMHS service activities provided through the TFC service model assists the child or youth in achieving client plan goals and objectives; improving functioning and well-being; and helps the child or youth to remain in a family-like home in a community setting; thereby avoiding residential, inpatient, or institutional care.

The TFC service model is intended for children and youth who require intensive and frequent mental health support in a family environment. The TFC service model allows for the provision of certain SMHS service activities available under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit as a home-based alternative to high level care in institutional settings such as group homes and, in the future, as an alternative to Short-term Residential Therapeutic Programs (STRTPs). The TFC home also may serve as a step down from STRTPs. The SMHS service activities provided through the TFC service model should not be the only SMHS that a child or youth would receive. Children and youth receiving SMHS service activities through the TFC service model must receive Intensive Care Coordination (ICC) and other medically necessary SMHS, as set forth in the client plan.

Data Reporting

The county and state require data collection associated with PWB including eligibility status, ICC/IHBS services provided, and the tracking of CFT meetings. BHS providers utilize internal tracking methods such as CCBH reports to monitor Pathways to Well-Being Eligible (Class) or Eligible for Enhanced Services (Subclass) status and ICC/IHBS services that are provided in a program. In order to track CFT meetings, BHS Providers are expected to use the Evidenced Based Practice (EBP) button on the Services Encounter Screen to record all CFT meetings for youth whenever a provider attends or facilitates a CFT meeting. Providers will enter service indicator **ID 92 Child Family Team** when the service being billed has been provided within a CFT meeting. This includes CFT meetings for youth Eligible for Enhanced Services, youth that do not have an open CWS case and CWS or Probation initiated CFT meetings.

Bulletins

PWB Bulletins are used to inform and provide procedures. Bulletins are located at RIHS website in the Pathways Bulletin section: https://theacademy.sdsu.edu/programs/rihs/pathways/

Trainings

All direct service staff shall obtain the following on-line trainings from the RIHS 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
- San Diego County Probation Department Overview eLearning

Additionally, classroom trainings are available to all mental health treatment providers.

Forms

Client related forms specific to Pathways to Well-Being which must be completed include the following:

Form (Please always refer to RIHS website for current version)	Details

Eligibility for Pathways to Well-Being and Enhanced Services	Provider completes electronically in CCBH within 30 days of intake, at reassessment, at discharge and at noted changes throughout the course of treatment.
Child and Family Meeting Facilitation Program Child and Family Team Referral	Completed any time there is an identified need for a CFT meeting for a youth in a mental health treatment program unless provider has an exception to facilitate their program CFT meetings, approved by COR.
Intensive Care Coordination Note	Provider completes electronically in CCBH. Form is utilized for all ICC services that occur outside of the Child and Family Team (CFT) meeting.
Child and Family Team Meeting Note	Provider completes electronically in CCBH. Form is utilized for documenting all CFT meetings, including Wraparound CFT meetings.
Child and Family Team Meeting Summary and Action Plan	Initiated by CFT Meeting Facilitation Program unless provider has an exception to facilitate their program CFT meetings, approved by COR.
Child and Family Team Meeting Confidentiality Agreement	Initiated by CFT Meeting Facilitation Program unless provider has an exception to facilitate their program CFT meetings, approved by COR.
Progress Report to Child Welfare Services	Provider completes and submits form to CWS (see secure region fax numbers on form) initially within 30 days of determining eligibility, any update (upon significant change or revised client plan), and at discharge.

Resources

DHCS Medi-Cal Manual Third Edition (2018):
https://www.dhcs.ca.gov/Documents/ChildrensMHContentFlaggedForRemoval/Manuals/Medi-Cal_Manual_Third_Edition.pdf

DHCS Integrated Core Practice Model Guide (2018):
http://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN%2018-022%20Integrated%20Core%20Practice%20Model%20and%20Integrated%20Training%20Guide/Integrated_Core_Practice_Model.pdf

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

Short Term Residential Therapeutic Programs (STRTP)

California's **Continuum of Care Reform (CCR)**, AB403 (2015) and AB1997 (2016), requires that Residential Care Level (RCL) group homes who serve foster youth and/or non-minor dependents (NMD) transition to licensure as an STRTP. The legislation ensures that youth with the most acute mental health treatment needs receive specialized, trauma informed and intensive treatment focused on stabilization to allow for a successful transition to a family setting.

IPC and CFT Meeting

Prior to placement in an STRTP, all children and youth shall participate in a **Child and Family Team meeting** and be evaluated by the **Interagency Placement Committee (IPC)** to ensure that the youth's needs cannot be met in a less restrictive environment and that they meet the criteria listed in All County Letter No. 17-22 , including that the child/youth:

- Does not meet criteria for inpatient care and has been assessed as requiring the level of services provided by an STRTP in order to maintain their safety and well-being,
- And one of the following:
- Meets **medical necessity** criteria for Medi-Cal Specialty Mental Health Services,
- is assessed as **seriously emotionally disturbed**, or
- is assessed as **requiring the level of services** provided by the STRTP in order to meet their behavioral or therapeutic needs, or
- meets criteria for **emergency placement** prior to determination by the IPC

The IPC consists of representatives from Child Welfare Services (CWS), Probation, and Behavioral Health Services as well as representatives from Public Health, and Educational sectors. Interagency Placement Committee meetings are held weekly by both Probation and CWS. For children 6-12 years old, placement in an STRTP shall not exceed 6 months. For children age 13 and up, placed under supervision of CWS, the placement shall not exceed 6 months. For children age 13 and up, placed under supervision of Probation, the placement in an STRTP shall not exceed 12 months. **Placement criteria and extension requests** beyond the stated timelines are outlined in **All County Letter No. 17-22**. For more information regarding **Child and Family Team meeting** requirements for youth placed in an STRTP, please reference **Section D**, **Child and Family Team** of the OPOH.

STRTP Services

STRTPs shall have a contract with the MHP to provide Specialty Mental Health Services (SMHS) and shall apply for and maintain **Mental Health Program Approval for STRTP**. Children/youth placed in an STRTP shall receive intensive treatment services in a therapeutic milieu, outlined in

Section D: Intensive Services. STRTPs shall also provide **Aftercare Services** for up to 90 days after children and youth discharge from the STRTP to promote stabilization and permanency in the new living environment. The Utilization Management process for STRTPs is outlined in **Section D**: **Authorization Process for Intensive Services**. The process for serving out of county Medi-Cal Clients in an STRTP is outlined in **Section D: Out of County Medi-Cal Clients**. STRTPs are required to comply with the program, documentation and staffing requirements outlined in the **Interim Mental Health Program Approval for STRTP** and the **Interim STRTP Regulations** provided in MHSUDS Information Notice NO.: 17-016.

References

All County Letter No. 17-22, STRTP Placement Criteria, Interagency Placement Committee, Second Level Review for Ongoing Placements
http://www.cdss.ca.gov/Portals/9/ACL/2017/17-122.pdf?ver=2018-01-10-151213-733.

Interim Mental Health Program Approval:
https://www.dhcs.ca.gov/services/MH/Documents/PPQA%20Pages/Interim_Protocol_for_STRTP_Mental_Health%20_Approval.pdf

Interim STRTP Regulations:
https://www.dhcs.ca.gov/services/MH/Documents/PPQA%20Pages/Interim_STRTP_Mental_Health_Regulations_Draft.pdf

https://www.dhcs.ca.gov/services/MH/Documents/PPQA%20Pages/MHSUDS_Information_Notice_17-016_STRTP.pdf
https://www.dhcs.ca.gov/formsandpubs/Documents/Joint_Info_Notice_MHSUDS_IN_16-002_CDSS_ACIN%20_06-16_Re_Pathways_CCR.pdf

https://www.dhcs.ca.gov/services/MH/Documents/MHSUDS_Info_Notice_18-017_Participation_in_CFT_Assessments_Claiming.pdf

BHS Pathways to Well-Being and Continuum of Care Reform Programs

BHS PWB and CCR Program staff are available to provide outreach assistance to BHS providers in all aspects of PWB and CCR implementation. This includes assisting providers with utilizing ICC and IHBS in accordance with the DHCS Medi-Cal Manual, as well as technical assistance with group home providers who are transitioning to a STRTP. The PWB and CCR Program teams work collaboratively and in partnership with BHS providers, CWS, Probation, and Youth/Family Support Partners. Program staff can be reached through the RIHS website link below.

https://theacademy.sdsu.edu/programs/rihs/pathways/

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 affected 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.

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.