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

for

SPECIALTY MENTAL HEALTH SERVICES

under

THE REHABILITATION OPTION

and

TARGETED CASE MANAGEMENT SERVICES

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

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LOS ANGELES COUNTY
LOCAL MENTAL HEALTH PLAN

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CHAPTER 1

Service, Documentation, and Reimbursement Basics

GENERAL SERVICE AND REIMBURSEMENT RULES

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GENERAL SERVICE AND REIMBURSEMENT RULES

O V E R V I E W

With the federal approval of the Medi-Cal Specialty Mental Health Services Consolidation waiver program on September 5, 1997, the State Department of Mental Health implemented standardized regulations with the adoption of Chapter 11, *Medi-Cal Specialty Mental Health Services*, in Division 1 of Title 9, California Code of Regulations (CCR). This modified some of the rules under which mental health services are provided and claims for reimbursement are made.

This document reflects the current rules for direct services reimbursed by Medi-Cal and County General Funds (CGF). CGF not only provide the federally required match dollars for Medi-Cal services (with the exception of EPSDT), but also provide for services to persons who cannot afford private care and do not qualify for any other health care funding source.

Chapters 2, 4, and 5 include the definitions for Consolidated Medi-Cal services that are reimbursable under the federal Rehabilitation Option and Targeted Case Management. Besides providing the definition of the service, other clarifying information such as service activities, documentation requirements, minimum staffing requirements, billing unit, site and contact requirements, and lockouts (limits regarding other services that can be billed on the same day), are included. The symbol "§" placed in this document denotes “Section” and is followed by the associated regulation’s numerical code. California regulations, State Letters and informational Notices referenced in this Manual can be accessed through the internet. See Appendix for website addresses.

S E R V I C E P H I L O S O P H Y

Medi-Cal services provided under the federal Rehabilitation Option focus on client needs, strengths, choices and involvement in treatment planning and implementation. The goal is to help clients take charge of their lives through informed decision-making. Services are based on the client's long-term goals/desired result(s) from mental health services concerning his/her own life and his/her diagnosis, functional impairment(s), symptoms, disabilities, life conditions and rehabilitation readiness. Services are focused on achieving specific, measurable objectives to support the client in accomplishing his/her desired results. Program staffing is multi-disciplinary and reflects the cultural, linguistic, ethnic, age, gender, sexual orientation and other social characteristics of the community that the program serves. Families, caregivers, human service agency personnel and other significant support person are encouraged to participate in the planning and implementation process in meeting the client's needs, choices, responsibilities and desires. Programs are designed to use both licensed and non-licensed personnel who are experienced in providing services in the mental health field.

MEDI–CAL REIMBURSEMENT RULES

Key Points Applicable to One or More Mode of Services

⇒ **A Provider must be either certified as a Mental Health Rehabilitation Provider** (§1810.435) **or licensed** by State DHS as a Psychiatric Hospital Service, Inpatient Hospital Service, or Outpatient Hospital Service to be eligible for reimbursement for providing Medi-Cal services.

⇒ **Hospital outpatient departments** as defined in Title 22, §51112, operating under the license of a hospital **may only provide services in compliance with licensing requirements**.

⇒ **Every claim must be supported by a note that must be present in the clinical record prior to the submission of the claim** (SDMH Contract, Exhibit A, Attachment 1, Appendix C).

⇒ **All covered services must be provided under the direction of:** a physician; a licensed/registered/waivered psychologist, clinical social worker, or a marriage and family therapist; or a registered nurse. Examples of service direction include, but are not limited to:

- being the person providing the service;
- acting as a clinical team leader;
- direct or functional supervision of service delivery; or
- approval of Client Care/Coordination Plans.

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

⇒ **Services shall be provided within the staff person's scope of practice** (§1840.314) **and his/her employers' job description/responsibility**. The local mental health director shall be responsible for assuring that services provided are commensurate with the professionalism and experience of the staff utilized.

⇒ **The time required for documentation and travel must be linked to the delivery of the reimbursable service** [§1840.316(a)(3)].

⇒ **Services to collaterals of deceased clients may only be claimed to County General Funds.**

⇒ **Coordination of services may be claimed** under Mental Health Services, Medication Support, or Targeted Case Management as a "plan development" service activity. Please refer to the definition of plan development noted in Chapter 2, "Mental Health Services" section. Plan development occurring in Day Treatment Intensive, Day Rehabilitation, or Adult Residential programs is a part of the inclusive rate for that service.

⇒ **Travel time is reimbursable if the travel is necessary to the provision of a service that the client could not obtain because of their mental illness.** If travel time is extensive, the note should document distance traveled to support the claim.

⇒ **Transportation services are not reimbursable** [§1810.355(a)(1)]. These costs could be factored into the overall expense (rate) of the service.

⇒ **Missed Appointments (and no services provided) are not reimbursable** (SDMH Letter No.: 02-07). This includes missed appointments at the provider's site, the client's home, or elsewhere in the community. While documenting a missed appointment or a voice mail/telephone message for a client is important, this time or travel time to a missed appointment cannot be claimed when no services are provided.

⇒ **Services are non-reimbursable by Medi-Cal when**:

- provided in a jail or prison setting [CCR, Title 22, §50273(a)(1-8)].
- provided to persons aged 22 through 64 who are residents of an Institution for Mental Disease (IMD) [§1840.312(g)]. An IMD is defined as a hospital nursing facility, or other institution that has minimally more than 16 beds and is primarily engaged in providing diagnosis, treatment or care of persons with mental illness, including medical attention, and related services (§1810.222.1); [Title 42, Code of Federal Regulations, §435.1009(b)(2)]. As such, a free standing Psychiatric Hospital or a State Hospital qualifies as an IMD.
- a client under 21 years of age resides in an IMD other than a Psychiatric Health Facility (PHF) that is a hospital or an acute psychiatric hospital, **except** if the client under 21 years of age was receiving such services prior to his/her 21st birthday. If this client continues without interruption to require and receive such services, the eligibility for Federal Financial Participation (FFP) dollars continues to the date he/she no longer requires such services, or if earlier, his/her 22nd birthday.
- lock-out rules that appear in Chapter subsections of this Manual restrict conditions of a claim.

⇒ **Services provided to children or adolescents in a juvenile hall setting are only reimbursable when the minor has been adjudicated for suitable placement.** Judicial legal orders from the court must be issued and indicate that the continuing detention in the juvenile hall setting is for the safety and protection of the minor based on criteria outlined in [WIC, Section 628]; i.e., the minor is **not** being detained for reasons related to arrest or violation of probation.

⇒ **Services of clerical support personnel are not reimbursable** [§1830.205(b)(3]. While it may be appropriate at times to record in the clinical record activities or observations of these personnel, their cost are included in overhead rates, for which the Department receives a percent of Medi-Cal reimbursement, so should not be separately claimed.

- ⇒ **Clerical activities performed by any staff are not reimbursable. While it is important to document in the clinical record when information is faxed or mailed, these activities are clerical and are not reimbursable. They should be documented in a separate note from the reimbursable service identifying that no time was claimed for these activities.**

- ⇒ **Supervision time is not reimbursable.** Supervision focuses on the supervisee's clinical/educational growth (as when meeting to monitor his/her caseload or his/her understanding of the therapeutic process) and is **NOT** reimbursable time. Supervision time required by Department policy or State licensing boards always falls within this definition and, thus, is never reimbursable. If a contact between a supervisor and supervisee does not fall within these definitions, but focuses instead on client needs/planning, the time is **not** considered supervision and **may** be claimed.

- ⇒ **Personal care services performed for the client are not reimbursable** (SDMH Letter No.: 01-01). These would include examples such as grooming, personal hygiene, assisting with medication, child or respite care, housekeeping, and the preparation of meals.

- ⇒ **Conservatorship investigations are not reimbursable.**

- ⇒ **Vocational, Educational, Recreational, and Socialization Activities are not reimbursable** [§1840.312(a)(b)(c) and (d)]. Activities which focus on skills specific to vocational training, academic education, recreation, or socialization activity are **not** reimbursable. Hence, Socialization is not reimbursable if the activities consist of generalized group activities that do not provide systematic individualized feedback to specific targeted behaviors of the clients involved. Similarly, Vocational services for the purpose of actual work or work training, whether or whether not the client is receiving wages, is not reimbursable by Medi-Cal. **However**, when the activities are used to achieve a therapeutic goal, the mental health service that was provided should be documented and is reimbursable by many payers. Reimbursable services can be delivered at a work, academic, or recreational site; as long as the interventions focus on aiding the client to integrate into the community, access necessary resources, or maximize interpersonal skills. Please see Appendix item, "Examples of Medi-Cal Reimbursable and Non-Reimbursable Vocational, Educational, Recreational, and Socialization Activities".

GENERAL DOCUMENTATION RULES

⇒ **Timeliness of documentation -** For services that require documentation for each contact or daily notes, DMH policy requires that the documentation be completed within 24 hours or by the close of the next business day following the delivery of the service. (see December 1, 2003, LAC-DMH memo "Documentation of Mental Health Services" in the Appendix).

⇒ **Notes must be legible. Notes that are not legible are not reimbursable.**

⇒ **The use of white-out is not permitted.** If an error is made, it should be lined-through with a single line, the word "error" noted next to the line-through, initialed, and dated.

⇒ **References to other clients in a client's record may only be by first name or name initials.**

⇒ **If abbreviations are used, they shall be standard, industry-accepted abbreviations.**

⇒ For **out of sequence documentation**, the date of service appears in the left hand column, and the chart note begins with, "Late Entry. Note written on [insert date]." (See Progress Note samples in Appendix).

⇒ **Special client needs as well as associated interventions directed toward meeting those needs must be documented** [DMH Policy 104.8]:

- **visually and hearing impairments**
- **client's whose primary language is not English -** documentation must show that services were either offered in the client's primary language and/or that interpretive services were offered. Clients should not be expected to provide interpretive services through friends or family members. (See DMH Policy #202.21, "Language Interpreters", for further information.)

  NOTE: Because assistance is documented, it does not necessarily mean it is claimable. Claimed notes for services must show how the service assists the client in accessing services or is a service intervention. The assistance must be claimed in accord with the focus of the client contact and the staff providing the service.

- **cultural or linguistic issues**

  NOTE: In order to obtain and/or transmit culturally and linguistically accurate information from clients who do not speak English as a first language, the Department has translated some of its forms into other languages. Whenever non-English forms are used, the English translation version must be printed on the back of the same page. If that is not possible, the English version must be placed immediately adjacent to the non-English version in the clinical record.

⇒ **Signature Requirements**

- Staff must sign (or the electronic equivalent) any progress note he/she writes and include his/her professional license or job title (SDMH Contract, Exhibit A, Attachment 1, Appendix C).
- When more than one staff participates in the same service, only one signature is required (except for required co-signature situations), but the names of any staff participating in the service must be included in the note, along with his/her time (See Progress Notes sample in the Appendix).
- Co-signatures may **NEVER** be used to allow a staff person to perform a service that is not within his/her scope of practice. Co-signing a Mental Health Services note means that the co-signer has supervised the service delivery and assumes responsibility and liability for the service.

MEDI-CAL MEDICAL NECESSITY

D E S C R I P T I O N

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

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

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

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

1. **An "included" DSM IV Diagnosis.** (See Appendix Item "Medi-Cal Included Diagnoses"**)**

   NOTE: Having a diagnosis that is not "included" does not exclude a client from having his/her services reimbursed AS LONG AS he/she also has an "included" diagnosis as the primary diagnosis, and services/interventions are directed toward the impairment resulting from that "included" diagnosis.

   On the clinical side of the IS, all DSM IV diagnoses are listed, both those "included" and "excluded" for Medi-Cal reimbursement. On admission, up to three diagnoses may be chosen on Axis I and two on Axis II. Additional diagnoses can be made and entered at anytime or existing diagnoses can be changed.

   The primary diagnoses of an episode will be the diagnosis associated with a claim and for Medi-Cal <u>must</u> be an "included" diagnosis. On the IS, clinicians may only choose between the first diagnosis listed under Axis I and II to identify the primary diagnosis for an episode.

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

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

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

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

1. The person has an included diagnosis (see Appendix for listing)
2. The person has a condition that would not be responsive to physical care based treatment

AND

3. Persons who do not meet the medical necessity criteria listed above will meet the medical necessity criteria per EPSDT [Title 22, §51340(e)(3)] eligibility when specialty mental health services are needed to correct or ameliorate a defect, mental illness, or condition.

EPSDT Supplemental services should **not** be approved if it is determined that the service to be provided is accessible and available in an appropriate and timely manner as another service available from the provider.

Mental Health Services should not be approved in home and community based settings if it is determined that the total cost incurred for providing such services to the minor is greater than the total cost to the Medi-Cal program in providing medically equivalent services at the minor's otherwise appropriate institutional level of care, where medically equivalent services at the appropriate level are available in a timely manner.

DOCUMENTATION FOR MEDICAL NECESSITY

It is important to understand that while documentation rules include specific points at which medical necessity must be <u>verified</u>, these are not the only points at which the medical necessity criteria must be met. **Every claimed service must meet the test of medical necessity; i.e., the service must be directed toward an included diagnosis, and the impairments that are a result of that diagnosis have interventions aimed at maintaining, reducing, or minimizing the effect of the diagnostic symptoms or impairment on a client's life. Each time a service is claimed, the staff person who delivered the service and submitted the claim is saying that he/she believes that the service met all medical necessity criteria.**

This is the sequence of documentation that supports the demonstration of on-going medical necessity:

- It begins with the completion of the Diagnostic Screening tool. If a client appears to meet all the medical necessity criteria and Department treatment parameters, he/she may be referred for intake.
- The completion of the Assessment establishes the specific impairments of a client and the certainty of an included diagnosis.
- The demonstration of medical necessity is carried forward into the client plan where the diagnosis and impairments are used to establish treatment goals and the planned interventions are expected to effect the client's impairments.
- Progress Notes document, and thus support, the presence of medical necessity, that each service delivered is an intervention service identified on the client plans. Progress Notes should also note progress the client is making toward his/her goals.
- At least every six months and before a new client plan is written, progress toward the goals established on the current client plan must be documented. Decisions can then be made regarding appropriate goals and interventions based on the diagnosis and impairments for the next six months.

At least every year, when the Coordination Plan is rewritten, the Coordinator is requested to formally reaffirm on the Coordination Plan that each of the medical necessity criteria continues to exist.

CLIENT CARE/COORDINATION PLAN
(LAC-DMH Policy No.: 104.9)

Consistent with the philosophy and requirements of state and federal funding sources, the Client Care/Coordination Plan focuses on individualized, strengths-based services; recognizes the necessity of a full continuum of care as well as the coordination of care across agencies; addresses linguistic and interpretive needs; supports family involvement and encourages client participation and agreement with the plan. It provides an overview of a client's care by encompassing all services except crisis services.

The LAC-DMH Client Care/Coordination Plan consists of three basic pages and two addendum pages. The three basic pages are the Client Care Page, Signature Page, and Coordination Page. The two addendum pages are the Client Care Addendum and Signature Addendum.

A copy of the Client Care/Coordination Plan shall be offered to the client (State DMH Contract).

CLIENT CARE PAGE

The Client Care Page must clearly address the symptomology/impairments identified in the initial assessment or annual assessment update utilizing the client's strengths to achieve his/her goals. With the exception of a few programs that require unique Client Care Plans, completion of the Department approved Client Care Page of the CCCP is required prior to the end of the initial two-month Intake Period or within one month for clients with existing open episodes anywhere within the Los Angeles County DMH system of care. For Crisis Residential Services this Page of the CCCP must be completed within 72 hours of admission to the program. When provided, the following services must be associated with a goal/objective(s):

- Mental Health Services (Individual, Group, Collateral, Psychological Testing, and Therapeutic Behavioral Services)
- Medication Support Services
- Targeted Case Management Services
- Crisis Residential Services
- Transitional and Long Term Residential Services

Day Treatment Intensive, Day Rehabilitation, and any mental health services delivered when a client is in one of these Day programs must complete the on-line authorization Care Plan prior to the delivery of these services. However, these services along with any other services such as Network Provider (FFS), Vocational or Socialization services must be entered on the Coordination Page of the CCCP.

Client Care Page Elements (State DMH Contract with Los Angeles County except as otherwise noted)**:**

- A statement of long-term goals (treatment outcome) in the client's words (County DMH)
- Clinical/case management objectives that are (SMART) specific, measurable/quantifiable, achievable, realistic, time-bound and related to identified mental health impairments and diagnosis/symptamotology as documented in the Assessment
- Identified type(s) of services and associated interventions
- Outcomes when goals have been achieved or, at a minimum, every time the client plan has a scheduled review (County DMH)
- Client and family involvement
- Additional client contacts/relationships (County DMH)
- Linguistic and interpretive needs.(County DMH)

Client Care Page Update and Review Frequency:

The Client Care Page shall be updated as clinically appropriate, but at a minimum, shall be rewritten and outcomes documented (prior to the expiration of the goals) accordingly:

- Mental Health Services, Medication Support, Targeted Case Management, Socialization and Vocational services - Annually;
- Crisis Residential programs - Weekly;
- Transitional Residential programs – Every 6 Months;
- Long Term Residential programs –Every 6 Months;
- Therapeutic Behavioral Services – Every 3 Months
- Day Treatment Intensive programs – Every 3 Months;
- Day Rehabilitation – Every 6 Months.

After the Intake Period, any objective or service provided to the client that was not initially on the CCCP should be added to the Client Care Page immediately after the service is discussed or provided if it is expected to be an ongoing service. If the service is expected to be a one-time service, it does not need to be added to the Client Care Page. However, if the service is provided again, it should be added to the Client Care Page (i.e. the service has been provided twice).

SIGNATURE PAGE

A signed Signature Page is required for all goals/objectives on the Client Care Page of the CCCP.

Signature Page elements include:

- Required Signatures;
- Verification that the client was offered a copy of the goals/objectives stated on the client care page;
- Justification for lack of client or other signature if signatures have not been obtained.

Required Participants and Signatures for the Signature Page of the Client Care/Coordination Plan (State DMH Contract with Los Angeles County except as otherwise noted)**:**

- For all objectives: the Staff person who writes the objective (County DMH);
- For all medication support objectives: an MD/DO or NP;
- For services claimed to Medicare/Private Insurance: an MD/DO (Medicare and Private Insurance Carriers as noted in County DMH Policy 104.9);
- For all other objectives: one of these State Approved Category of Staff (SACS):
  - licensed MD/DO *(Note: the DMH only hires physicians who are certified or eligible for certification by the American Board of Psychiatry and Neurology),*
  - certified NP, registered CNS, Registered Nurse (RN),
  - licensed or registered <u>and</u> waivered PhD/PsyD,
  - LCSW or registered MSW (Associate Clinical Social Worker - ACSW) or out-of-state licensed-ready waivered MSW, and
  - licensed MFT or registered MFT (MFT Intern) or out-of-state licensed-ready waivered MFT
- For all objectives: the client or a Parent, Authorized Caregiver, Guardian, Conservator, Personal Representative for treatment *(Note: the signature of the person who has signed the Consent for Services is preferred; if the person signing the Consent for Services is unavailable, a caregiver of the client or a client of any age may sign).*

When age appropriate, the client should always be encouraged to participate by signing.

When a required participant does not sign the Client Care Coordination Plan, regular efforts must be attempted to obtain their approval with the plan. A written explanation of the client's or other's refusal or unavailability to sign, or disagreement with the plan, must be documented.

Each time a goal/objective is reviewed/rewritten, new signatures must be obtained.

COORDINATION PAGE

A Coordination Page is required for all services except crisis and 24-hour services.

Coordination Page Elements include:

- Confirmation of completion of Initial Assessment/Annual Assessment Update;
- Types of services provided;
- Cycle Months;
- Contact information for the Single Fixed Point of Responsibility (SFPR);
- All services from all agencies involved in the client's care (including DTI and DR) and excluding emergency services;
- Provider identification – provider number;
- Periods of authorized services – start and end dates;
- Approval of services by the SFPR (written or verbal)

Coordination Plan, Cycle Date and Update Frequency:

- For **new** clients receiving ongoing services, the Coordination Page, as with the Client Care Page, must be completed by the end of intake, i.e., within two months of the date of intake.
- When additional services are added to the Client Care Page, these shall be included in the Coordination Plan and will follow the time frames cited above under Client Care Page.
- The Coordination Page must be updated as services are added or deleted/ended. If chosen, a new Coordination Page may be started annually prior to the first day of the Cycle Month or it may be continued until a new Coordination Page is needed due to space limitations. A new Coordination Page must be completed if the SFPR changes.

Signature Requirements:

- The Single Fixed Point of Responsibility's approval.

CHAPTER 2

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

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

SERVICE DEFINITIONS AND RULES
- **Mental Health Services**
  - **Assessment (A)**
  - **Individual (I)**
  - **Collateral (C)**
  - **Psychological Testing (PsyT)**
  - **Group (G)**
- **Medication Support Services (Meds or MSS)**
- **Crisis Intervention (CI)**
- **Targeted Case Management (TCM)**

SERVICE OVERVIEW & REIMBURSEMENT RULES

GENERAL RULES

Mental Health Services are to be provided under the direction of a physician, a licensed/registered/waivered psychologist, clinical social worker or marriage and family therapist, or a registered nurse. Examples of service direction include, but are not limited to: 1) being the person directly providing the service; 2) acting as the clinical team leader; 3) direct or functional supervision of service delivery; or 4) approval of client care plans. It should be noted that it is not required for the person providing direction to be physically present at the service site to exercise direction.

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

All Individual, Collateral, Family, and Group Services must have authorization from the Department's Central Authorization Unit prior to delivery when delivered in conjunction with Day Treatment Intensive or Day Rehabilitation.

DOCUMENTATION RULES APPLICABLE TO ALL SERVICES BASED ON MINUTES OF TIME

(**See** also Chapter 1, "General Documentation Rules" and subsequent sections for each type of service, for specific rules applicable to only that service.)

Frequency of Documentation:

⇒ Every service contact for mental health services, medication support services and crisis intervention must be documented.

⇒ When the same staff person delivers more than one type of service in a session, a single claim **may** be submitted for the predominant service as long as the chart documentation predominantly reflects that service.

⇒ If two staff provide different services in a single contact, two notes should be written with each staff submitting his/her own claim, using the appropriate procedure codes for the separate claims (See Appendix item, “Documentation for Services Based on Minutes of Time).

⇒ When services are being provided to or on behalf of a client by two or more staff at one point in time, each person's involvement shall be documented in the context of the mental health needs of the client. (§1840.314)

⇒ **Each chart note must include (DMH Policy No. 104.8):**

- date of service
- type of service: for MHS indicate specific type – A, I, C, PsyT, G; for all others their general type - Meds or MSS, CI, TCM
- procedure code
- location of service
- duration of service (time) in hours:minutes for each participating staff
  - Except for those services entered in other than the group module of the IS, the rendering provider's time is broken out by face-to-face and other (e.g., documentation/travel) time.
  - For group services, the rendering provider records in the record and reports only "total time".
  - All other staff participants of a service, whether group or non-group, record and report "total time" only.
- for group, the number of clients to whom the service will be claimed.
- description of service provided – what was attempted and/or accomplished during the contact toward the attainment of a treatment goal.
- a description of changes in medical necessity, when appropriate.
- for each staff claiming for the service, his/her specific contribution/intervention.

Signature Requirements

(**See** also, Chapter 1, "Signature Requirements," under "General Documentation Rules.")

⇒ Mental Health Services provided by unlicensed staff without a bachelor's degree in a mental health related field or two years of experience (paid or unpaid) delivering mental health services must have all progress notes co-signed by an physician, licensed psychologist, RN, LCSW, or MFT until the experience/education requirement is met and the supervisor has determined that the staff person is competent to provide services and document independently**.**

Site and Contact Requirements:

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

- Services may either be face-to-face or by telephone with the client or significant support persons and may be provided anywhere in the community. Activities such as plan development, reports/referrals, and other similar paperwork are reimbursable without a face-to-face or phone contact.

SERVICE DEFINITIONS AND RULES

MENTAL HEALTH SERVICES

Definition (§1810.227):

"Mental Health Services" mean those individual or group therapies and interventions that are designed to provide reduction of mental disability and improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral.

NOTE: For seriously emotionally disturbed children and adolescents, Mental Health Services provides a range of services to assist the child/adolescent to gain the social and functional skills necessary for appropriate development and social integration.

Types of Service Activities:

NOTE: All of the services described below are reimbursed at the Mental Health Services rate.

A. Assessment (§1810.204)

Assessment is a clinical analysis of a client's history and current status of mental, emotional, or behavioral disorder; relevant cultural issues and history; diagnosis; and testing procedures.

NOTE:

- The Assessment must include a clear reason for referral, signs and symptoms that support the diagnosis, and the severity of impairment within the client's setting (work, school, community).
- Psychological Testing is a psychodiagnostic assessment of personality, development assessment and cognitive functioning. For children, referrals are made to clarify symptomatology, rule out diagnoses and help delineate emotional from learning disabilities.

For claiming and reimbursement, assessment service activities are categorized into the types below. Their definitions and the claiming codes may be found in the "Guide to Procedure Codes".

- <u>Assessment</u>
  - Psychiatric Diagnostic Interview
  - Interactive Psychiatric Diagnostic Interview
- <u>Psychological Testing</u>
  - Psychological Testing inclusive of report writing
- <u>No Contact – Report Writing</u>

B. **Therapy (§1810.250)**

A service activity which is a therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments. Therapy may be delivered to an individual or group and may include family therapy at which the client is present.

Note: This service may only be claimed by a licensed, registered, waivered, or student professional (with co-signature) in the following disciplines: Physician, Clinical Psychologist, Social Workers, Marriage and Family Therapist, and Nurse Practitioner/Registered Nurse.

Medi-Cal only reimburses for services to or on behalf of an identified beneficiary. Services to collaterals of identified beneficiaries should be claimed as collateral services to the appropriate payer.

For claiming and reimbursement, therapy service activities are categorized into the types below. Their definitions and the claiming codes may be found in the "Guide to Procedure Codes".

- Individual Therapy
  - Individual Psychotherapy
  - Interactive Individual Psychotherapy
  - Individual Psychotherapy with Evaluation and Management (for physicians and nurse practitioners only)
  - Individual Interactive Psychotherapy with Evaluation and Management (for physicians and nurse practitioners only)
  - Family Psychotherapy with one client present/represented
- Group Therapy
  - Group Psychotherapy
  - Interactive Group Psychotherapy
  - Family Psychotherapy with more than one client present/represented
  - Multi-family Group Psychotherapy

C. **Rehabilitation (§1810.243)** (not Medicare reimbursable)

A service activity which includes assistance in improving, maintaining, or restoring one or more individuals' functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, and support resources.

Note: This service may be claimed by any staff acting within his/her training and job description. If unlicensed staff are involved in the delivery of a mental health service to an individual, whether independently or along with licensed staff, the service may only be claimed as rehabilitation.

For claiming and reimbursement, rehabilitation service activities are categorized into the types below. Their definitions and the claiming codes may be found in the "Guide to Procedure Codes".

- Individual Rehabilitation
- On-going support to maintain employment
- Group Rehabilitation (family and non-family)

D. Plan Development (§1810.232) *Not billable to Medicare as a stand-alone service.*
Plan Development is a service activity that may include any or all of the following:

- development of Client Care/Coordination Plans
- approval of plans
- monitoring of the client's progress

For claiming and reimbursement:

- Because of the State requirement for client participation in plan development, this activity should only on rare occasions occur outside the context of a client contact with the time required to write up the Plan included as a part of documentation time for that contact/Procedure Code.
- On the rare occasions when it does not occur as a part of a contact with a client, it should be claimed [§1840.316 (b)(4)] as an Individual Rehabilitation service because there is no code specific to this service.
- Team Conferences/Case Consultation is a type of plan development activity whose definition and claiming code may be found in the "Guide to Procedure Codes".

E. Collateral (§1810.206) (not Medicare reimbursable)
A service activity to a significant support person* in a client's life with the intent of improving or maintaining the mental health status of the client. The client may or may not be present for this service activity.

Outside agency staff, school teachers, board and care operators are **not** significant support persons.

For claiming and reimbursement, collateral service activities have only one definition and code. It may be found in the "Guide to Procedure Codes".

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

Claiming Rules (applies to Mental Health Services, Medication Support Services, Crisis Intervention, and Targeted Case Management):

⇒ The exact number of minutes used by persons providing a reimbursable service shall be reported and billed. In no case shall more than 60 units of time be reported or claimed for any one person during a one-hour period. In no case shall the units of time reported or claimed for any one person exceed the hours worked [§1840.316 (b)(1)].

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* Significant support persons means persons, in the opinion of the client or the person providing the service who have or could have a significant role in the successful outcome of treatment, including, but not limited to the parents or legal guardian of a client who is a minor; the legal representative of a client who is not a minor; a person living in the same household as the client; the client's spouse, and relatives of the client. (§1810.246.1)

⇒ A service is an individual service when one client is present or represented for the service and is a group when more than one client is present or represented at the same time for a service.

⇒ When a person provides service to, or on behalf of, more than one client at the same time, the person's time must be prorated to each client. When more than one person provides a service to more than one client at the same time, the time utilized by all those providing the service shall be added together to yield the total claimable services. The total time claimed shall not exceed the actual time utilized for claimable services [§1840.316 (b)(2)].
(See also "Documentation Rules" above and DMH Policy No. 104.9.)

⇒ The time required for documentation and travel is reimbursable when the documentation or travel is a component of a reimbursable service activity, whether or not documentation time is on the same day as the reimbursable service activity [§1840.316 (b)(3)].

Lockouts (applies to all Mental Health Services):

⇒ Mental Health Services are not reimbursable on days when Crisis Residential Treatment Services [§1840.364(a)], Psychiatric Inpatient Hospital Services [§1840.215(c)], or Psychiatric Health Facility Services [§1840.370(h)] are reimbursed, except on the day of admission to any of these facilities.

⇒ Mental Health Services are not reimbursable when provided by Day Rehabilitation or Day Treatment Intensive staff during the same time period that Day Rehabilitation or Day Treatment Intensive Services are being provided [§1840.360(b)].

⇒ Mental Health Services are not reimbursable when provided during the same time that Crisis Stabilization-Emergency Room or Urgent Care is provided. Exception is Targeted Case Management [§1840.368(b)].

⇒ Providers may not allocate the same staff's time under the two cost centers of Adult Residential and Mental Health Services for the same period of time [§1840.362(b)].

Service Specific Documentation Requirements:

Please **review** minimum documentation requirements under "REIMBURSEMENT AND DOCUMENTATION RULES For Services Based on Minutes of Staff Time" above, in addition to noting other required documentation detailed below for specific services.

Required Documentation Based on Mental Health Service Provided:

Initial Assessment

Initial clinical evaluations must be completed within 60 days of intake for a new admission (no open episodes in the entire system), or within 30 days when the client is being opened to a new service, but has other open episodes. (DMH Policy No. 104.9)
The initial clinical assessment contains (SDMH contract, Exhibit A, Attachment 1, Appendix C and DMH Policy No.104.9):

- Presenting problem(s) and relevant conditions affecting the client's physical and mental health status, i.e., living situation, daily activities, social support
- Impact of functional impairments on life functioning
- Clear indication as to why the client is seeking treatment at this time; and a behavioral history that includes:
  - Previous treatment dates
  - Previous and present mental health providers
  - Previous therapeutic interventions and responses
  - Relevant family information
  - Relevant lab reports, consultations, and sources of clinical data, and
  - Past and present use of tobacco, alcohol, and caffeine, as well as illicit, prescribed, and/or over-the-counter drugs.
- **For children and adolescents,** pre-natal and peri-natal events and complete developmental history
- A brief psychosocial history
- A relevant mental health status examination with a narrative describing symptoms
- A medical summary that contains a brief relevant medical history
- History of psychiatric medications that have been prescribed, including dosages of each medication
- Client's self-report of allergies and adverse reactions to medications, or lack of known allergies/sensitivities are clearly documented
- Client's strengths in achieving service plan goals
- Special status situations that present a risk to the client are documented and updated when changes occur
- Adequate information to assess the client's needs in order to formulate a treatment plan
- A five axis DSM (current edition) “included” diagnosis as specified in CCR, Title 9, Chapter 11, §1830.205(b)(1)(A-R) (see Appendix – Chapter 1) that is consistent with the presenting problems, history, mental status evaluation and/or other assessment data.
- Housing, employment, and benefit status

Annual Assessment Update (DMH Policy No. 104.9)

The Annual Assessment Update shall be completed annually for clients receiving ongoing services, including Medication Support and Targeted Case Management. This document will be used to verify medical necessity on an annual basis.

The annual assessment shall include:

- ⇒ A description of the progress the client has made toward meeting goals since the last assessment
- ⇒ Current symptoms/problems
- ⇒ A description of any co-occurring (substance abuse) issues that influence the symptoms, impairment, and treatment
- ⇒ A description of any cultural factors that influence the symptoms, impairment, and treatment
- ⇒ A current assessment of the client's
  - ➢ Living arrangements
  - ➢ Social support systems
  - ➢ Financial benefits
  - ➢ Daily activities/vocational/educational activities
  - ➢ Physical health (note any changes from last assessment)
  - ➢ Hospitalizations and use of Psychiatric Mobile Response and Crisis Stabilization, and
  - ➢ Use of the legal system
- ⇒ A description of how the client meets medical necessity

Psychological Testing:

Psychological Testing is recorded in the clinical record and reported into the IS in hours:minutes and claimed time includes report writing. Providers may submit separate claims, with appropriate accompanying documentation for both the administration of tests and the preparation of the report in accord with the date the services were actually delivered. Only the final report shall be placed in the clinical record. Raw data must be securely maintained by the clinic.

Group Services:

Group is a MHS activity <u>delivered to more than one client</u> at the same time (this includes services to a family/families or other collaterals when claims will be submitted for more than one client represented during the contact) which focuses on the mental health needs of the client(s).

When a staff member provides service to, or on behalf of, more than one client at the same time, this is a group service. The staff member's time is prorated to each client by the IS, based on the number of persons receiving a service. This number must include both DMH and non-DMH clients in order to ensure that Medi-Cal is not claimed time for services to non-beneficiaries.

When more than one staff person participates in the group, one staff must be selected as the Rendering Provider. The Rendering Provider is responsible for documenting the group service;

the claim will be submitted under that staff person's name (See examples in Appendix item, “Documentation for Services Based on Minutes of Time”).

Case Conferences/Case Consultations:
The chart note shall include the reason for the presentation, the issues discussed, and the services suggested (LAC-DMH Policy 104.9). The name of all staff in attendance should be recorded whether or not a claim is filed for their time. The service must be documented in a single note within a provider by a designated staff person who must document the specific contribution of any staff for whom they will claim time. General statements regarding a person’s note or contribution are not sufficient.

MEDICATION SUPPORT SERVICES

Definition and Services Activities (§1810.225):

Medication support services include prescribing, administering, dispensing and monitoring of psychiatric medications or biological necessary to alleviate the symptoms of mental illness which are provided by a staff person, within the scope of practice of his/her profession.

The service may include:

⇒ evaluation of the need for medication
⇒ evaluation of clinical effectiveness and side effects of medication
⇒ obtaining informed consent
⇒ medication education (including discussing risks, benefits and alternatives with the client or significant support persons)
⇒ (when claiming Medication Support only) plan development related to the delivery of this service and/or assessment of the client
⇒ prescribing, dispensing and administering of psychiatric medications

NOTE: Allowable costs may include drugs and laboratory tests related to the delivery of this service.

The following types of medication support services have separate procedure codes (See "Guide to Procedure Codes" for definitions and codes)

- Individual Medication Service (face-to-face)
- Brief Medication Visit (face-to-face)
- Comprehensive Medication Service (including phone calls and collaterals)

Claiming Rules:

See also "Claiming Rules" under "Mental Health Services" section above. The notes below provide additional information:

⇒ Medication Support Services shall be provided within the applicable scope of practice by Physicians, Nurse Practitioners, Registered Nurses, Psychiatric Technicians, Licensed Vocational Nurses, and Pharmacists (§1840.346). Physicians can prescribe, dispense, and administer. NP's can prescribe with appropriate protocols and administer. RN's, PT's, and LVN's can administer. Pharmacists can dispense and administer.

⇒ Medication Support Services that are provided within a residential or day program shall be billed separately from that service as Medication Support Services.

⇒ When Medication Support services are provided to a client by a physician (writing a prescription) and nurse (giving an injection) the time of both staff should be claimed. If both staff are providing the same service, one note is written, covering both staff and one claim

submitted that includes the time of both staff. If two staff provide different services during the contact, two notes should be written, with each staff submitting his/her own claim. From either a claiming or documentation perspective, it makes no difference whether the services were delivered during the same contact or in separate contacts.

⇒ If a staff person ineligible to claim Medication Support participates in the contact, then the ineligible staff person must write a separate note documenting service time as either TCM or Individual or Group, in accord with the service provided.

Lockouts:

Medication Support Services are not reimbursable on days when Psychiatric Inpatient Services [§1840.215(c)] or Psychiatric Health Facility Services [§1840.370(g)] are reimbursed, except for the day of admission to either service.

A maximum of four hours of Medication Support Services per calendar day is Medi-Cal reimbursable (§1840.372).

Documentation (LAC-DMH Policy 104.9 and, as noted, Title 9, §851):

Medication Support General Guidelines:

- <u>Informed Consent</u>
  - A voluntary client shall be treated with psychotropic medications only after s/he has been informed by the physician of his/her right to accept or refuse such medications and that consent, once given, can be withdrawn at any time. (Title 9, §851 & DMH Policy 104.9)
  - The information received by the client and documented by the physician shall include, but need not be limited to (Title 9, §851):
    - nature of the client's mental condition
    - reason(s) for taking the medication(s), including the likelihood of improving or not improving without the recommended medication
    - type, range of frequency and amount, and method and duration of taking medication(s), and
    - probable side effects which commonly occur and any possible additional side effects which are likely to occur if medication is taken beyond three (3) months; the client shall be advised in accord with the medication(s) prescribed that the symptoms of tardive dyskinesia are potentially irreversible and may continue or appear after medications have been discontinued.
  - For directly-operated programs, an Outpatient Medication Review Form, signed by the client, indicating that the above information has been discussed with the client, shall be completed by the physician and placed in the Med Notes Section of the client record or the above information shall be noted on Medication Notes in the Med Note Section of the clinical record. When the cross-reference note for the

audit trail is made on the Progress Notes, it should be noted that the Medication Review was completed during the contact.

- Reasons for changes in medication and/or dosage shall be clearly documented by the psychiatrist and, when required, supported by a new Outpatient Medication Review Form or commensurate documentation on the Medication Note.
- A description of what was attempted and/or accomplished at the time the service was provided shall be included in the Medication Notes.
- If medication is prescribed/dispensed/administered by appropriate licensed staff, that chart note shall contain the following relative information:
  - name, dosage, and quantity of the medication;
  - frequency and route of administration.
- There shall be documentation at each visit indicating the client has been questioned about:
  - side effects,
  - response to medication(s), both positive and adverse, and
  - client's compliance with the medication regime.
- When non-physician staff provides medication support services (within scope of practice), the documentation is to include:
  - description of the client's response to the medication,
  - side effects, and
  - compliance with medication.
- If outside physicians prescribe psychotropic medications, complete information about such medications shall be documented in the chart.
- **For children only:** Clients for whom medications are necessary in the evaluation and treatment of their psychiatric disorder shall be instructed to obtain a physical examination. If the client or family/caregiver refuses, this refusal shall be noted in the chart.

CRISIS INTERVENTION

Definition and Services Activities (§1810.209):

A service lasting less than 24 hours to or on behalf of a client for a condition that requires a more timely response than a regularly scheduled visit and is delivered at a site other than a Crisis Stabilization program. Service activities include but are not limited to Assessment, Collateral, and Therapy.

There is only one code which exists for this service: (See "Guide to Procedure Codes" for definition and code)

- Crisis Intervention

Site and Contact Requirements:

Services may either be face-to-face or by telephone with the client or significant support persons and may be provided anywhere in the community (§1840.336). If an out-of-office situation is presented to a staff person as a crisis, then the staff finds the situation calm when he/she arrives, the service may still be claimed as Crisis Intervention if the crisis described in the originating call is so documented (See Appendix for Quality Improvement Communiqué No. 4, December 13, 1993).

NOTE: Crisis Intervention may be claimed for On-Duty work if:
1) the client has an open episode
2) the situation meets all criteria in this section
3) documentation is done in compliance with the requirements stated later in this section
4) the Provider is budgeted for Crisis Intervention

Medi-Cal Lockouts (§1840.366):

⇒ Crisis Intervention is not reimbursable on days when Crisis Residential Treatment Services, Psychiatric Health Facilities Services, Psychiatric Nursing Facility Services, or Psychiatric Inpatient Hospital Services are reimbursed, except for the day of admission to those services.
⇒ The maximum amount billable for Crisis Intervention in 24 hour period is 8 hours.

Minimum Documentation Requirements:

In addition to the rules cited in Chapter 1, "Medi-Cal Reimbursement Rules," and “General Documentation Rules,” as well as Chapter 2, "Service Overview and Reimbursement Rules,” each note must also include the following information:
⇒ Acuity of client or situation which jeopardizes client’s ability to maintain community functioning
⇒ A description what was attempted and/or accomplished by service staff at the time the service was being provided
⇒ Plan for subsequent service, if applicable

TARGETED CASE MANAGEMENT

Definition (§1810.249):

Targeted Case Management are services that assist a client to access needed medical, educational, social, pre-vocational, vocational, rehabilitative, or other community services for eligible clients. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure client's access to service and the service delivery system; monitoring of the client's progress; and plan development.

NOTE:

- Targeted Case Management is NOT skill development, assistance in daily living, or training a client to access services him/herself. These services are MHS.
- While more than one program may deliver Targeted Case Management services, the same type of case management, such as money management, should not be provided by more than one program.

Service activities:

Targeted Case Management service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure the client's access to service and the service delivery system; monitoring of the client's progress and plan development (§1810.249).

- Linkage and Consultation - The identification and pursuit of resources including, but not limited to, the following:
  - Interagency and intra-agency consultation, communication, coordination, and referral
  - Monitoring service delivery to ensure a client's access to service and the service delivery system
  - Monitoring of the client's progress
- Placement Services - Supportive assistance to the client in the assessment, determination of need and securing of adequate and appropriate living arrangements, including, but not limited to the following:
  - Monitoring of the client's progress
  - Locating and securing an appropriate living environment
  - Locating and securing funding
  - Pre-placement visit(s)
  - Negotiation of housing or placement contracts
  - Placement and placement follow-up
  - Accessing services necessary to secure placement

- Plan Development is defined as a service activity which consists of development of Client Care/Coordination Plans, approval of client plans, and/or monitoring of a client's progress (§1810.232).

NOTE: Plan development, while usually a part of a face-to-face or phone contact with a client and/or significant other, may occur and be claimed absent these elements.

Lockouts (§1840.374):

Targeted Case Management Services are not reimbursable on days when the following services are reimbursed, except for the day of admission or for placement services as provided below:

⇒ Psychiatric Inpatient Hospital Services
⇒ Psychiatric Health Facility Services
⇒ Psychiatric Nursing Facility Services

Targeted Case Management Services solely for the purpose of coordinating placement of the client upon discharge from the psychiatric inpatient hospital, psychiatric health facility or psychiatric nursing facility may be provided during the 30 calendar days immediately prior to the day of discharge, for a maximum of three nonconsecutive periods of 30 calendar days or less, per continuous stay in the facility.

Exception: Targeted Case Management **is reimbursable** during the same time Crisis Stabilization is provided. (No other specialty mental health service is reimbursable during the same period Crisis Stabilization is reimbursed.) [§1840.368 (b)]

Minimum Documentation Requirements:

See Chapter 1, "Medi-Cal Reimbursement Rules," and “General Documentation Rules,” as well as Chapter 2, "Service Overview and Reimbursement Rules.”

Frequency of Documentation:

For Targeted Case Management documentation is done either for every service contact, daily, or as a weekly summary.

CHAPTER 3

Regulations and Requirements for Special Services Populations

THERAPEUTIC BEHAVIORAL SERVICE (TBS)
MULTI-SYSTEMIC THERAPY (To Be Developed)
COMMUNITY-BASED WRAP AROUND (To Be Developed)

SERVICE DEFINITION AND RULES

THERAPEUTIC BEHAVIORAL SERVICE (TBS)

Definition:

Therapeutic behavioral service (TBS) is an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) supplemental specialty mental health service as defined in Title 9, CCR, §1810.215. TBS is an intensive one-to-one, short-term* outpatient treatment intervention for beneficiaries under age 21 with serious emotional problems or mental illness who are experiencing a stressful transition or life crisis and need additional short-term* specific support services. TBS must be needed to prevent placement in a group home at Rate Classification Level (RCL) 12 through 14 or a locked facility for the treatment of mental health needs, or to enable a transition from any of those levels to a lower level of residential care (SDMH Contract, Exhibit A, Attachment 1, Section Y).

Therapeutic behavioral services are intended to supplement other specialty mental health services by addressing the target behavior(s) or symptom(s) that are jeopardizing the child/youth's current living situation or planned transition to a to a lower level of placement. The purpose of providing TBS is to further the child/youth's overall treatment goals by providing additional TBS during a short-term* period.

Whenever the Mental Health Plan (MHP) is involved prior to the placement of a child/youth in a facility at RCL 12 or above, the entire range of mental health services, including TBS, that might allow the child/youth to remain in the current living situation, must be considered in time to prevent the out-of-home placement whenever possible and appropriate (SDMH Information Notice No.: 00-03).

Description:

TBS is one-to-one therapeutic contact to provide the child/youth with skills to effectively manage the behavior(s) or symptom(s) that is the barrier to achieving residential placement at the lowest appropriate level.

A TBS staff is available on-site to provide individualized one-to-one behavioral assistance and one-to-one interventions to accomplish outcomes specified in the written client plan. The critical distinction between therapeutic behavioral services and other rehabilitative MHS(s) is that a significant component of TBS is having the staff person on-site and immediately available to

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* TBS is intended to be *short-term* time-limited services; however, there is no specific time limit on the duration of TBS. TBS may be continued even after a favorable outcome has been achieved when it is determined that TBS is still medically necessary, e.g., when the child/youth has met the behavior goals of his/her TBS plan, but continuation of TBS is still necessary to stabilize the behavior and reduce the risk of regression (SDMH Letter No.: ***04-12***). This information is documented in the progress notes.

intervene for a specified period of time. The designated time periods may vary in length, depending upon the needs of the child/youth.

Criteria for Medi-Cal Reimbursement of TBS:

⇒ **Full Scope Medi-Cal beneficiary under age 21 years <u>and</u> meets medical necessity criteria**

⇒ **Member of the Certified Class (must meet at least one of the following:**

- Is in a Group Home of Level 12 or above or locked treatment facility which is not an Institute for Mental Disease
- Is being considered by the county for placement in one of the above facilities
- Has undergone at least one emergency psychiatric hospitalization related to their current presenting disability in the preceding 24 months; or
- Has previously received TBS while a member of the Certified Class.

⇒ **Need for TBS - must meet criteria (both):**

- The child/youth is concurrently receiving other specialty mental health services (Targeted Case Management or Medication Support alone do not meet this criteria).
- It is highly likely, in the clinical judgment of the mental health provider that without the additional short-term support of TBS that:
  - The child/youth will need to be placed in a higher level of residential care or:
  - TBS is needed to support transition to a lower level of residential care.

Conditions under which TBS are not reimbursable through Medi-Cal:

⇒ **When the need for TBS is <u>solely:</u>**

- For the convenience of the family or other caregivers, physician, or teacher.
- To provide supervision or to assure compliance with terms and conditions of probation
- To ensure the child/youth's physical safety or the safety of others e.g., suicide watch, or
- To address conditions that are not part of the child/youth's mental health condition

⇒ **When the child/youth is:**

- In a hospital, mental health unit, psychiatric health facility, nursing facility, or crisis residential facility.
- In juvenile hall **and** when ineligible for Medi-Cal (<u>CFR</u>, Title 42, §435.1008 & §435.1009; <u>CCR</u>, Title 22, §50273(1-9). (See Chapter 1, "Medi-Cal Reimbursement Rules" for clarification on when services to minors in a juvenile hall are reimbursable.)
- A resident of an Institution for Mental Disease (IMD), a free-standing Psychiatric Hospital or a State Hospital (<u>CCR</u>, Title 9, Chapter 11, §1840.312(g)&(h) and

§1840.360-374; CFR, Title 42, §435.1008 and §435.1009; and CCR, Title 22, § 50273(1-9).

- Unable to sustain non-impulsive self-directed behavior and engage in appropriate community activities without full-time supervision, and improvement in these areas is seen as non-attainable.
- Able to sustain non-impulsive self-directed behavior, handle themselves appropriately in social situations with peers, and who is able to appropriately handle transitions during the day.

⇒ **TBS may not be claimed for on-call time for the staff person(s) providing TBS.**

Authorization Requirements:

(State DMH Information Notices 02-08, 04-03, and SDMH Contract, Exhibit A, Attachment 1, Section Y)

NOTE: Information and forms regarding specific requirements for authorization for TBS, including the expedited authorization process, required Notices of Action to clients, and approved service time periods, is obtainable from the LAC-DMH Central Authorization Unit or through their website: https://dmhdowney1.co.la.ca.us.

Authorization Requirement:

Providers must request and obtain payment authorization for TBS from the Central Authorization Unit (CAU) in advance of the delivery of the services included in the authorization request. The authorization replaces the provider's obligation under State DMH Letter 99-03, page 6, to review the TBS component of a beneficiary's client plan monthly. The requirement for approval in advance of the delivery of TBS applies to direct one-to-one TBS and related service activities*, but does not include the initial assessment that determines whether TBS criteria are met or to the initial development of the TBS client plan.

Frequency of Authorization:

Providers must request and obtain payment authorization for TBS in advance of service delivery initially and for all subsequent authorizations. There are no limits to the number of TBS re-authorizations that can be requested; as long as the beneficiary continues to meet all eligibility criteria, TBS can be authorized.

Initial Authorization:

Initial payment authorization requests for more than 30 days for direct one-to-one TBS exceeding 12 hours per day will not be approved by the CAU. Initial payment authorization requests for greater than 30 and up to 60 days will be accepted if accompanied by a TBS assessment, which is completed through the LAC-DMH CAU Day Treatment and TBS Authorization System secured website: *https://dmhdowney1.co.la.ca.us* (see **"NOTE"** above).

The provider shall identify at least one behavior and one intervention in the initial authorization request that TBS is expected to address.

The initial authorization request does not require the presence of a TBS assessment nor TBS client care plan when the request in for thirty (30) days or less and/or when the purpose of the initial authorization request is to do an assessment to determine whether the client can benefit from the service.

Fourth Payment Authorization:

For the purpose of State monitoring of the LAC-DMH TBS authorization process, when a provider has been approved for a fourth authorization request, the provider shall provide a summary of the TBS services provided; justification for the additional authorization; and a termination plan with clearly established timelines and benchmarks, including a planned date for termination of TBS, in writing, directly to the LAC-DMH CAU. The CAU will forward the information to the LAC-DMH Director and to the Deputy Director, Systems of Care, at State Department of Mental Health, within five working days of the authorization decision.

NOTE: The Fourth Payment Authorization does not preclude further authorizations for the beneficiary as long as the requirements for TBS continue to be met.

Expedited Authorization Process (SDMH Letter No. 04-03)**:**
(See also March 24, 2004 LAC-DMH letter, "Implementation of State DMH Letter No.: 04-03")

In cases in which a provider indicates, or the Department determines, that following the normal 14 calendar day time frame for making a decision on an authorization request for TBS could seriously jeopardize the child/youth's life or health or ability to attain, maintain, or regain maximum function, the Department will follow an expedited authorization process. A provider's request to use the expedited authorization process will be honored.

To request an expedited review, the provider will complete a section at the end of the authorization request in which he/she certifies that the client, who meets the certified class requirements and medical necessity, also satisfies one of the following three criteria:

- Without TBS, the beneficiary is likely to be placed at a higher level of care or to require acute psychiatric hospitalization within the next 14 days.
- The beneficiary is ready to transition to a lower level of residential placement within the next 14 days but cannot do so without TBS.
- The request is for the continuation of previous TBS authorization, which will end in 14 days, or less, resulting in a gap in services, and the request is being made before the end of the previously authorized service period.

The on-line certification process for an expedited review will be accomplished through electronic signature. To submit an *Expedited Review Request,* a clinician must have on file with the CAU an *Electronic Signature Agreement for Clinician Requesting Expedited Review Request for Therapeutic Behavioral Services.* The form is accessed via a link on the TBS Archived Messages Page on the website. The electronic signature agreement is Executive Director, Head of Service or Program Manager approval that the identified clinician is authorized to submit an

expedited review request. The provider's signature is further identified as the formal certification under penalty of perjury that the expedited review of the MHP payment authorization request is necessary. Original signatures are required. Agencies/providers attempting to submit an Expedited Review Request for a clinician, who is not listed as approved with a signature on file, will be provided the link to the signature agreement form.

Upon receipt of a client plan with an expedited request, the CAU will make a decision to approve, deny or modify the request no later than three working days after receipt. The CAU may extend the three-working-day time period by up to 14 calendar days if the beneficiary requests an extension, or if the CAU identifies a need for additional information.

Authorization Procedures:

Payment authorization for TBS is available through the LAC-DMH website (see "**NOTE,**" page 3-3). TBS is authorized by number of calendar days, and may not exceed 60 days per authorization request. Requests for 60 days may be granted only when a current TBS assessment is on file with the CAU. Provider may request a 30-day authorization if there is no TBS assessment on file and the purpose of the authorization request is to complete one.

Authorization Time Lines:

The LAC-DMH CAU's decision and notice to approve, deny, or modify the authorization request for TBS must be provided as expeditiously as the child/youth's mental health condition requires and no later than three working days after the receipt of the request for authorization. The three-working-days time period may be extended by up to 14 calendar days, if requested by the child/youth or if the LAC-DMH CAU identifies a need for additional information and documents the need and how the extension is in the child/youth's best interest. This information is documented in the LAC-DMH CAU's authorization records.

Dispute Resolution Process:

An informal and a two-tiered formal review process are available to the provider for resolving authorization disputes involving denial, modification, reduction or termination of a request for authorization. It is recommended that providers initially attempt to resolve issues with the CAU for such action. Providers have a right to appeal a denial or modified request for payment authorization within 90 days of the date of the notification.

Appeals Process:

The informal review process involves an informal discussion between the provider and the Provider Relations Unit to reconsider the original authorization request. A provider can seek information and clarification to express concerns regarding clinical or administrative issues by contacting Provider Relations in person, in writing, by telephone at (213) 738-3311 or by fax at (213) 351-2024, to initiate the informal review process. A Provider Relations Specialist will respond to providers concerns, problems and disputes within 10 business days. If a dispute is not

resolved to the provider's satisfaction, the provider retains the right to initiate the formal appeal process.

When resolution is not to the providers' satisfaction, the provider may request a first level (Level I) formal appeal. The provider may file a formal appeal by submitting a written request using the "Formal Review of Provider Appeal (Level I)" form, along with any additional supporting documentation to support the appeal. In addition, the provider should identify a contact person: name, address, email, telephone and fax. This appeal package should be mailed to DMH – Provider Relations Unit, 550 S. Vermont Ave., Suite 704A, Los Angeles CA 90020.

The appeal, with all required documentation, will be forwarded to the Clinical Management Review Committee (CMRC) appointed by the Local Mental Health Plan (LMHP). No members of the committee will have been involved in the referral, treatment or authorization of services regarding the provider's dispute. The CMRC will issue a written decision within thirty calendar days of receipt of the appeal from Provider Relations. If the appeal is for administrative decisions, the appeal shall be forwarded within 24-hours to the Director of the Bureau of Standards, Practices and Conduct for a written decision within thirty (30) calendar days of receipt of the appeal from Provider Relations. This approval, if based upon the same documentation submitted prior to the decision of the CAU, is retroactive to the date of the original request. If this approval is based upon additional documentation presented to the Medical Director, but not previously submitted to the CAU, the approval date will coincide with the Medical Director's decision date. If the appeal is denied, there will be a written response to the provider, within thirty days of the formal appeal.

If the first level formal appeal is denied, the provider has the right to file a second level (Level II) formal appeal to the office of the Medical Director. The second level formal appeal must be submitted within thirty (30) calendar days from the date of the notice of the First Level Appeal decision. Providers request a second level formal appeal by submitting a copy of the original *Provider Appeal Form*, along with copies of any supporting documentation. The provider will be notified within thirty calendar days of the decision of the Medical Director. The decision of the Office of the Medical Director, LMHP, is final.

First and second formal levels of appeals may be forwarded to:

County of Los Angeles
Department of Mental Health
Provider Relations Services
550 South Vermont Ave., Room 704A
Los Angeles, CA 90020

FAX: (213) 351-2024

Documentation requirements (for Authorization Decision):

TBS Assessment (SDMH Information Notice No. 02-08):
(See also Chapter 2, "Mental Health Services", required documentation for "Initial Assessment")

The Assessment must show that the child meets medical necessity criteria and that there is a need for specialty mental health services, in addition to TBS. Additionally, the assessment must show that the child/youth has specific behaviors and/or symptoms that require TBS. The Assessment must:

- Identify the child/youth's *specific* behaviors and/or symptoms that jeopardize continuation of the current residential placement or the *specific* behaviors and/or symptoms that are expected to interfere when a child or youth is transitioning to a lower level of residential placement.
- Describe the critical nature of the situation, the severity of the child or youth's behaviors and/or symptoms, what other less intensive services have been tried and/or considered, and why these less intensive services are not or would not be appropriate.
- Provide sufficient clinical information to demonstrate that TBS is necessary to sustain the residential placement or to successfully transition to a lower level of residential placement and can be expected to provide a level of intervention necessary to stabilize the child or youth in the existing residential placement or to address behaviors and/or symptoms that jeopardize the child or youth's transition to a lower level of care.
- Identify what changes in behavior and/or symptoms TBS is expected to achieve and how the child's therapist or treatment team will know when these services have been successful and can be reduced or terminated.
- Identify skills and adaptive behaviors that the child or youth is using now to manage the problem behavior and/or is using in other circumstances that could replace the specified problem behaviors and/or symptoms.

A copy of the TBS Assessment, with original signature is maintained in the client's file at the provider agency.

TBS Client Care Plan and Plan Content:

The TBS Client Plan is intended to provide clinical direction for one or a series of short-term interventions to address very specific behaviors and/or symptoms as identified by the assessment process. The written client treatment plan for TBS, as a component of an overall client plan for specialty mental health services must identify all of the following (SDMH Information Notice No. 02-08):

- Clearly specif*y* behaviors and/or symptoms that jeopardize the residential placement or the transition to a lower level of residential placement and that will be the focus of TBS.

- A specific plan of intervention for each of the targeted behaviors or symptoms identified in the assessment and the client plan.
- A specific description of the changes in the behaviors and/or symptoms that the interventions are intended to produce, including a time frame for these changes.
- A specific way to measure the effectiveness of the intervention at regular levels and documentation of changes in planned interventions, when the original plans are not achieving expected results.
- A transition plan that describes in measurable terms how and when TBS will be decreased and ultimately discontinued, either when the identified benchmarks (objectives that are met as the client progresses towards achieving his/her plan goals) have been reached or when reasonable progress towards goals is not occurring and, in the clinical judgment of the individual or treatment team, are not reasonably expected to be achieved. This plan should address the manner of assisting parents/caregivers with skills and strategies to provide continuity of care when TBS is discontinued.
- As necessary, a plan for transition to adult services when the beneficiary turns 21 years old and is no longer eligible for TBS. This plan should also address assisting parents/caregivers with skills and strategies to provide continuity of care when this service is discontinued, when appropriate in the individual case.
- If the beneficiary is between 18 and 21 years of age, notes regarding any special considerations that should be taken into account, e.g., the identification of an adult case manager.

A copy of the TBS Client Plan with original signature(s) is maintained in the client's file at the provider agency.

Frequency of TBS Client Care Plan:

Subsequent to the initial Client Care Plan that is submitted to the LAC-DMH CAU for authorization of services, the TBS Client Care plan is ***completed*** on-line whenever TBS re-authorization is requested.

Client Plan Addendum (SDMH Information Notice No. 02-08)**:**

The Client Plan Addendum ***shall*** document the following situations:

- Significant changes in the child or youth's environment, e.g., a change in residence, since the initial development of the TBS client plan.
- The TBS provided to the child or youth has not been effective and the child or youth is not making progress as expected towards identified goals. In this situation, there must be documented evidence in the chart and any additional information from the provider indicating that alternatives have been considered, and the reason that only the approval of the requested additional hours/days for TBS, instead of or in addition to the alternatives, will be effective (SDMH contact, Exhibit A, Attachment 1).

Client Care/Coordination Plan (CCCP):

Once authorized by the CAU, TBS must be included in the Coordination Plan section of the CCCP document.

Progress Notes (SDMH Information Notice No. 02-08)**:**

(See also "General Rules" and "Documentation Rules" under Chapter 2.)

- Progress Notes should clearly and specifically document the occurrence of the:
  - Specific behaviors and/or symptoms that threaten the stability of the residential placement or prevent transition to a lower level of residential placement;
  - Delivery of the significant interventions identified in the TBS client plan;
  - Progress being made in stabilizing the behaviors and/or symptoms by changing or eliminating maladaptive behaviors and increasing adaptive behaviors.
- Progress notes must include a comprehensive summary covering the time that services were provided, but need not document every minute of service time.
- A progress note that includes interagency case conferencing (including the placing agency, therapist, clinical supervisor, and parent/caretaker when possible) shall be completed at least quarterly. *However, nothing precludes more frequent interagency case conferencing when needed and when in the interest of the client* (LAC-DMH Policy 104.9).
- Progress Notes must be legible and signed, and include the staff person's professional license or job title.

Frequency of Documentation:

Progress notes must be completed for each separate contact/shift.

Notification to State DMH re TBS:

Within 30 days of the inception of the **provision of TBS** to a beneficiary, the provider shall complete and submit the required notification directly to State DMH and to LAC-DMH (at the respective addresses listed on the form). Additionally, the provider shall submit a **termination** notification to LAC-DMH (at the address on the form). The originals shall be filed in the progress note section of the client's file.

Notices of Action (NOAs):

The LAC-DMH shall issue Notices of Action (NOAs) regarding therapeutic behavioral services consistent with the requirements of CCR, Title 9, Chapter 11, §1850.210 (see Appendix, Chapter 3 for this regulation). Within one month of being issued, copies of these NOAs shall be submitted to the State DMH. (SDMH Letter No.: 99-03)

Staff Qualifications:

TBS is delivered by a physician, registered nurse, or licensed, waivered, registered psychologist, clinical social worker, or marriage and family therapist (LAC-DMH Children's System of Care, "Plan for Implementing Therapeutic Behavioral Services," 1999.)

Staff who deliver TBS but are not a physician, RN, or licensed psychologist, MFT, or LCSW must have:

- A college degree with one year full time equivalent experience working in a group home, hospital, S.E.D. designated classroom, day treatment, or other equivalent setting; **or**
- Two years college and three years of experience described in "1" above; **or**
- A high school diploma with three years experience as described in "1" above; **or**
- A DMH sponsored TBS certification for training and internship.

All staff delivering TBS must pass following same clearances, as required for residential facilities:

- Child Abuse Index check
- Department of Justice fingerprint check clearance (Live Scan)
- California Driver's License, DMV printout, and Insurance

Training and Supervision Requirements:

Individuals who assess beneficiaries to determine the need for TBS and individuals who provide direct one-to-one TBS must meet the requirements of the Final Judgment and Permanent Injunction in Emily Q v. Bonta, Case No. CV 98-4181 AHM (AIJx), United States District Court, Central District of California, which requires that TBS providers have training in behavioral analysis with an emphasis on positive behavioral interventions.

Staff delivering TBS will, at a minimum receive, 1 hour per week of individual supervision and group supervision twice each month. Staff delivering TBS must have access to a supervisor at all times during which they are actively delivering TBS.

CHAPTER 4

Regulations and Requirements for Services Based on Blocks of Time (Mode 10)

MEDI-CAL REIMBURSABLE SERVICES
- **Hours of Time**
  - **Crisis Stabilization**
- **Half or Full-Days of Time**
  - **Day Treatment Intensive (DTI)**
  - **Day Rehabilitation (DR)**

COUNTY GENERAL FUND REIMBURSABLE SERVICES
- **4-hour Blocks of Time**
  - **Socialization Services**
  - **Vocational Services**

MEDI-CAL REIMBURSABLE SERVICES BASED ON HOURS OF TIME

CRISIS STABILIZATION SERVICES

Definition of Service Activities and Site Requirements (§1810.210):

A service lasting less than 24 hours, to or on behalf of a client for a condition which requires a more timely response than a regularly scheduled visit. Service activities may include but are not limited to assessment, collateral, and therapy.

Crisis Stabilization must be provided on site at a licensed 24-hour health care facility or hospital-based outpatient program or a provider site certified by the State Department of Mental Health to provide Crisis Stabilization

NOTE: This is a bundled service and is not claimed by individual staff.

Procedure Codes:

Crisis Stabilization services have separate procedure codes based on site of delivery of services as noted below (See "Guide to Procedure Codes" for codes and definitions):

⇒ Crisis Stabilization - Emergency Room

⇒ Crisis Stabilization - Urgent Care Facility

Contact Requirements [§1840.338(b)(c)]:

⇒ Medical backup services must be available either on-site or by written contract or agreement with a hospital. Medical backup means immediate access within reasonable proximity to health care for medical emergencies. The Department shall define immediate access and reasonable proximity. Medications must be available on an as needed basis and the staffing pattern must reflect this availability.

⇒ All persons receiving Crisis Stabilization shall receive an assessment of their physical and mental health. This may be accomplished using protocols approved by a physician. If outside services are needed, a referral that corresponds with the person's need shall be made, to the extent resources are available.

Claiming Rules (§1840.322):

The billing unit for Crisis Stabilization is client time, based on hour blocks of time.

- Each hour block of crisis stabilization services to the client shall be claimed.
- Partial blocks of time shall be rounded up or down to the nearest one-hour increment with the exception of services lasting less than one hour, which shall always be rounded up to a one hour increment.

Note: Client time spent in the waiting room is not service time.

Lockouts (§1840.368):

Crisis Stabilization is not reimbursable on days when Psychiatric Inpatient Hospital or Psychiatric Health Facility or Psychiatric Nursing Facility Services are reimbursed, except on the day of admission to those services.

Crisis Stabilization is a package program and no other Medi-Cal services are reimbursable during the same time period this service is reimbursed, except for Targeted Case Management.

The maximum number of hours claimable to Medi-Cal for Crisis Stabilization in a 24-hour period is 20 hours.

Minimum Documentation Requirements:

(**See** also "General Documentation Requirements" in Chapter 1)

⇒ Date of Service
⇒ Type of Service delivered and Procedure Code
⇒ Acuity of Individual or situation which jeopardizes Individual's ability to maintain Community functioning
⇒ A description of what was attempted and/or accomplished by service staff including observation of the Individual
⇒ Time the Service Began and Ended
⇒ Plan for Subsequent Service, if applicable

Frequency of Documentation (SDMH contract, Exhibit A, Attachment 1, Appendix C):

Daily - a minimum of one progress note for every twenty-three hours for which services are billed.

Staffing Requirements (§1840.348):

Services must be provided by staff functioning within the State's scope of practice and employer job description/responsibilities.

1) A physician shall be on call at all times for the provision of those services which can only be provided by a physician.

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

3) At a minimum there shall be a ratio of at least one of the licensed/registered/waivered mental health professionals on site for each four persons (1:4) receiving Crisis Stabilization services at any given time.

4) If the client is evaluated as needing service activities that can only be provided by a specific type of licensed professional, such staff shall be available.

5) Other staff may be utilized by the program, according to need.

6) If Crisis Stabilization are co-located with other specialty mental health services, staff providing Crisis Stabilization must be separate and distinct from staff providing other services.

7) Staff included in required Crisis Stabilization ratios and minimums may not be counted toward meeting ratios and minimums for other services.

MEDI-CAL REIMBURSABLE SERVICES BASED ON HALF OR FULL DAY OF TIME

DAY TREATMENT INTENSIVE & DAY REHABILITATION

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

Authorization Requirement (SDMH Information Notices No(s) 02-6 & 02-08; State Contract, Exhibit A, Attachment 1):

The requirement for prior authorization also extends to outpatient mental health services (Individual, Collateral, Family, Group therapy and rehabilitation) planned for delivery on the same day the client is in the day treatment program. (SDMH Contract, Exhibit A, Attachment 1, "Requirements for DTI & DR", "Authorization and Service Requirements." This applies regardless of whether or not the outpatient mental health services are delivered within a single clinic or in a different clinic.

Definitions:

Both Day Treatment Intensive and Day Rehabilitation are packaged programs with services available at least three hours and less than 24 hours each day the program is open (§1810.213 & §1810.212, respectively)

(See “Billing” below for additional time requirements.)

Day Treatment Intensive (§1810.213)

Day Treatment Intensive service is a structured multi-disciplinary treatment program as an alternative to hospitalization, to avoid placement in a more restrictive setting, or to maintain the client in a community setting.

NOTE: For seriously emotionally disturbed children and adolescents, Day Treatment Intensive provides a range of services to assist the child/adolescent to gain the social and functional skills necessary for appropriate development and social integration. Interventions are intended to prevent hospitalization, placement in a more restrictive facility, or out of home placement. This service may be integrated with an education program. A key component of this service is contact with the families of these Individuals.

Day Rehabilitation (§1810.212)

Day Rehabilitation is a structured program of rehabilitation and therapy to improve, maintain, or restore personal independence and functioning, consistent with the requirements for learning and development which provides services to a distinct group of clients.

NOTE: For seriously emotionally disturbed children and adolescents, Day Rehabilitation focuses on maintaining Individuals in their community and school settings, consistent with their requirements for learning and development and enhanced self-sufficiency. Services emphasize delayed personal growth and development. This service may be integrated with an education program. A key component of this service is contact with the families of these Individuals.

Service Activities and Components:

Service Activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral (§1810.212 & §1810.213)

NOTE: Medication Support Services that are provided within a day program shall be billed separately from the Day Treatment Intensive or Day Rehabilitation programs [§1840.326(b)].

Day Treatment Intensive (DTI) and Day Rehabilitation (DR) programs are **required** to include the following minimum service components and shall be available at least a weekly average of 3 hours per day for full-day programs and an average of 2 hours per day for half-day programs (SDMH Contract, Exhibit A, Attachment 1). The service components must be developmentally and age appropriate (SDMH Letter No. 03-03)

⇒ **Community meetings** that occur at a minimum of once a day, but may occur more frequently as necessary, to address issues pertinent to the continuity and effectiveness of the therapeutic milieu, and actively involve staff and clients. The community meetings will address relevant items, including the schedule for the day, current events, individual issues clients or staff wish to discuss to elicit support of the group, conflict resolution within the milieu, planning for the day, the week, or for special events, old business from previous meetings, or from previous day treatment experiences, and debriefing or wrap up.

Staffing Requirements for Community Meetings:

- DTI - A staff person whose scope of practice includes psychotherapy.
- DR- Physician; licensed/waivered/registered psychologist, clinical social worker, MFT; registered nurse; psychiatric technician; LVN; or MH Rehabilitation Specialist.

⇒ **A therapeutic milieu**, i.e., a structured therapeutic program with the following service components:

Both DTI & DR **shall** provide the following:

- Skill building groups: These are groups where staff help clients identify barriers related to their psychiatric and psychological experiences and, through group interaction, become better able to identify skills that address symptoms and behaviors. Skill building will support learning and using adaptive behaviors.

- Adjunctive therapies: Non-traditional therapies involving staff and clients where the therapeutic intervention utilizes self-expressive modalities, e.g., art, recreation, dance, music. The modality is directed towards developing and enhancing skills towards client plan goals.

Additionally for DTI:

- Psychotherapy: The use of psychosocial methods within a professional relationship to assist the client or clients to achieve a better psychosocial adaptation; to acquire greater human realization of psychosocial potential and adaptation; to modify internal and external conditions that affect individuals, groups, or communities in respect to behavior, emotions, and thinking, in respect to their intrapersonal and interpersonal processes. **Psychotherapy shall be provided by licensed, registered, or waivered staff practicing within their scope of practice.**

  DTI **may** also include process groups, defined below, in addition to the service activities listed above.

Additionally for DR:

- Process Groups: Groups facilitated by staff to help clients develop the skills necessary to deal with their individual problems and issues by using the group process to provide peer interaction and feedback in developing problem-solving strategies and to assist one another in resolving behavioral and emotional problems.

  DR **may** include psychotherapy instead of process groups or in addition to process groups.

In the therapeutic milieu, specific activities are performed by identified staff and takes place for the continuous scheduled hours of operation for the program. The staff and activities teach, model, and reinforce constructive interactions; include peer and staff feedback to clients on strategies for symptom reduction, increasing adaptive behaviors, and reducing subjective distress; involve clients in the overall program, e.g., providing opportunities to lead community meetings and to provide feedback to peers, include behavior management interventions that focus on teaching self-management skills that children, youth, adults, and older adults may use to control their own lives, to deal effectively with future and present problems, and to function well with minimal or no additional therapeutic intervention.

These service components shall apply/be made available for at least a weekly average of 3 hours per day for full-day programs and an average of two hours per day for half-day programs:

⇒ Breaks between milieu activities and lunch or dinner breaks do not count towards the total hours of operation of the day program for purposes of determining minimum hours of service (SDMH Letter No. 03-03).

⇒ **At least one contact** (face-to-face or by an alternative method, e.g., e-mail, telephone, etc.) **per month with a family member**, caregiver, or other significant support person identified by an adult client, or one contact per month with the legally responsible adult for a client who is a minor. Adult clients may choose whether or not this service component is done for them. The contacts and involvement should focus on the role of the significant support person in supporting the client's community reintegration. It is expected that this contact will occur outside the hours of operation of the day treatment program.

⇒ A detailed **weekly schedule** identifying where and when the service components identified above will be provided and by whom shall be made available to clients and, as appropriate, to their families, caregivers, or significant support persons. The written weekly schedule shall specify the program staff, their qualifications, and their scope of responsibilities.

Other Required Service Components (SDMH Contract, Exhibit A, Attachment 1):

⇒ An established protocol for responding to clients experiencing a mental health crisis. The protocol shall assure the availability of appropriately trained and qualified staff and include agreed upon procedures for addressing crisis situations. The protocol may include referrals for crisis intervention, crisis stabilization, or other specialty mental health services necessary to address the client's urgent or emergency psychiatric condition (crisis services). If clients will be referred to crisis services outside the day treatment or intensive day rehabilitation program, the DTI or DR staff shall have the capacity to handle the crisis until the client is linked to outside crisis services.

⇒ A written program description for DTI and DR. Each provider of these services shall be required to develop and maintain this program description. The written program description shall describe the specific activities of the service and reflect each of the required components of the services described in this section.

Site and Contact Requirements [Day Treatment Intensive (§1840.328); Day Rehabilitation (§1840.330)]

There is a clearly established site for services although all services need not be delivered at that site.

Claiming Rules (§1840.318):

⇒ Day Treatment Intensive and Day Rehabilitation shall be billed as half days or full days of service.

⇒ The following requirements apply for claiming of services based on half-days or full days of time:

1. A half day shall be billed for each day in which the client receives face-to-face services in a program with services available four hours or less per day. Services must be available a minimum of three hours each day the program is open.
2. A full day shall be billed for each day in which the client receives face-to-face services in a program with services available more than four hours per day.

Clients are expected to be in attendance all the scheduled hours of the program, but a service may be claimed in unusual situations if the client has been in attendance at least 50% of the hours of operation of the program (SDMH Contract, Exhibit A, Attachment 1).

Lockouts (§1840.360):

Day Treatment Intensive & Day Rehabilitation services are not reimbursable on days when Crisis Residential Treatment Services, Inpatient Services, or Psychiatric Health Facility Services or Psychiatric Nursing Facility Services are reimbursed, except for the day of admission to those services.

Mental Health Services are not reimbursable when provided by Day Treatment Intensive or Day Rehabilitation staff during the same time period that Day Treatment Intensive or Day Rehabilitation services are being provided.

Two half day programs may not be provided to the same client on the same day.

Minimum Documentation Requirements:

(See also Chapter 1, "General Documentation Rules")

- Date of Service
- Type of Service delivered and Procedure Code
- Daily Notes (for DTI only): description of service provided. This includes a weekly schedule that shows:
  - the specific activities in which a client participates each day of his/her attendance along with a brief daily service note
  - the length of time of each activity
  - the total time of participation of the client for each day.
- Weekly Clinical Summaries (DTI only): Brief narrative describing what was attempted and/or accomplished toward the client goal(s) by the client and service staff.
- Weekly Summary (DR only): A description of what was attempted and/or accomplished toward the client goal(s), by the client and service staff.
- Daily activities in which the client participated must be reflected in the documentation.

Frequency of Documentation (SDMH contract, Exhibit A, Attachment 1, Appendix C):

- DTI: Daily Progress Notes on activities **and** a weekly clinical summary

- DR: Weekly summary

Signature Requirements:

(**See** also Chapter 1, "Signature Requirements," under "General Documentation Rules")

Weekly clinical summaries for DTI and weekly summaries for DR clients must be written and signed by the service provider and, if applicable, reviewed and co-signed by a physician, a licensed/waivered/registered psychologist, social worker or MFT, or a RN, who is either staff to the DTI or the person directing the service (SDMH Contract, Exhibit A, Attachment 1, Appendix C).

NOTE:

- Co-signatures may NEVER be used to allow a staff person to perform a service that is not within his/her scope of practice. The qualified staff person (see "Signature Requirements" above) co-signing a Day Rehabilitation note affirms they have supervised the service delivery and assume responsibility and liability for the service.
- DTI and DR progress notes written by unlicensed staff without a bachelor's degree in a mental health related field or two years of experience (paid or unpaid) delivering mental health services in the mental health field must have all progress notes co-signed by a mental health professional until the experience/education requirement is met.

Staffing Requirements:

Day Treatment Intensive

- DTI programs serving more than **12** clients must include staff from at least two of the staff categories listed in "Staffing Requirements for Day Treatment Programs" in the Appendix (§1840.350).

- At a minimum there must be an average ratio of at least one staff to **8** Individuals (1:8) in attendance during the period the program is open. Other staff may be utilized according to program need, but shall not be included as part of the ratio formula (§1840.350). The staff categories that meet this requirement appear in the Appendix item, "Staffing Requirements for Day Treatment Programs."

- At least one staff person must be present and available to the group in the therapeutic milieu for all scheduled hours of operation (SDMH Contract, Exhibit A, Attachment 1).

- Program staff may be required to spend time on day treatment intensive activities outside the hours of operation and therapeutic milieu, e.g., time for travel, documentation, and caregiver contacts (SDMH Contract, Exhibit A, Attachment 1). This time is not separately reimbursable.

NOTE: A physician; licensed/waivered/registered psychologist, social worker, MFT; or Registered Nurse must be included in the staffing for DTI programs since weekly clinical summaries must be written and/or co-signed by one of these disciplines. Also, other clinical services provided by the program may be appropriately provided by a clinician.

Day Rehabilitation

- At a minimum there must be an average ratio of at least one staff to **10** Individuals (1:10) in attendance during the period the program is open (See "Staffing Requirements for Day Treatment Programs" in Appendix for allowable staff categories). Other staff may be utilized according to program need, but shall not be included as part of the ratio formula (§1840.352).

- Programs serving more than **12** Individuals must include two staff identified in "Staffing Requirements for Day Treatment Programs" (See Appendix). (§1840.352)**.**

NOTE: While there is no specific State requirement for a physician, a licensed/waivered/registered psychologist, social worker, or MFT, or a RN to be a part of the minimum staffing, there are at least 2 situations which would require their inclusion: 1) the program is acting as Coordinator [the signature of a licensed/waivered/registered staff person is required on Coordination Plans] or 2) the program is providing clinical assessments and/or clinical/therapeutic services which are only within the scope of practice of licensed/waivered/registered staff.

Day Treatment Intensive and Day Rehabilitation:

Staff who are not solely used to provide DTI or DR services may be utilized according to program need, but shall not be included as part of the staff to client ratio formulas to meet staffing requirements listed above (SDMH Letter No.: 03-03).

A clear audit trail shall be maintained for staff who function as both Day Treatment Intensive or Day Rehabilitation staff and in other capacities (§1840.350 and §1840.352).

At least one day treatment staff person must be physically present in any room or other separate identifiable location in which the therapeutic milieu is being provided to one or more clients (SDMH Letter No.: 03-03)

NOTE: DTI/DR staff that is budgeted entirely (100%) to a DTI/DR program may not claim any other type of service.

COUNTY GENERAL FUND REIMBURSABLE SERVICES
Service and Documentation Requirements

SOCIALIZATION AND VOCATIONAL SERVICES

These services are NOT reimbursable by Medi-Cal; they are reimbursed by County General Funds (CGF).

Description and Service Activities:

Socialization Day Services

This is a bundled activity service for clients who require structured support and the opportunity to develop the skills necessary to move toward more independent functioning. The activities focus on recreational and/or socialization objectives and life enrichment. The activities include, but are not limited to:

- recreational activities
- cultural events
- linkages to community social resources
- other social supportive maintenance efforts.

Services may be provided to clients with a mental disorder who might otherwise lose contact with social or treatment systems.

Vocational Day Services (Skill Training and Development)

This bundled service is designed to encourage and facilitate individual motivation and focus upon realistic and attainable vocational goals. To the extent possible, the intent of these services is to maximize individual client involvement in skill seeking enhancement with an ultimate goal of self-support. These vocational services shall be bundled into a milieu program for chronically and persistently mentally ill clients who are unable to participate in competitive employment. These programs include, but are not limited to:

- vocational evaluation
- pre-vocational, vocational, or work training
- sheltered workshop
- job placement

The program stresses development of sound work habits, skills, and social functioning for marginally productive persons who ultimately may be placed in work situations ranging from sheltered work environments to part or full-time competitive employment.

Claiming Rules:

Both Socialization and Vocational activities are bundled services (not claimed by individual staff). The services are recorded in the clinical record and reported into the IS in units of 4 hour blocks of time. **See** "Guide to Procedure Codes" for appropriate code.

⇒ These services are recorded in the clinical record and reported into the IS in units of 4 hour blocks of time. Less than or equal to four hours is one block of time. Greater than four hours and up to eight hours is two blocks of time. Greater than eight and up to twelve is three blocks of time. (See "Quality Improvement Communiqué" No. 4, December 13, 1993, in Appendix.) No more than three blocks of time may be claimed in a day.

⇒ Costs for documentation are included in the rate for these services and shall not be separately billed.

Documentation Frequency (DMH Policy No. 104.9):

Weekly Summary

Minimum Documentation Requirements (DMH Policy No. 104.9):

See "General Documentation Rules" in Chapter 1.

Documentation will include:

- Dates of Service <u>and</u> number of blocks of time delivered for each date
- Procedure Code
- Weekly Summary containing:
  - an indication of the activities in which the client participated
  - a brief narrative describing what was attempted and/or accomplished toward the client goal(s) by the client and service staff toward meeting goals
  - the current functional level
  - the current functional impairment

Staffing

Any staff operating within his/her scope of practice may provide services.

CHAPTER 5

Regulations and Requirements for Services Based on Calendar Days

GENERAL RULES

ADULT RESIDENTIAL TREATMENT SERVICES
(Transitional and Long-Term)

CRISIS RESIDENTIAL TREATMENT SERVICES

PSYCHIATRIC HEALTH FACILITY

GENERAL RULES

Service Reimbursement by Calendar Days (§1840.320):

This applies to:
⇒ Adult Residential Treatment Services (Transitional and Long-Term)
⇒ Crisis Residential Treatment Services
⇒ Psychiatric Health Facility Services

Claiming Rules (§1840.320):

⇒ A day shall be billed for each calendar day in which the client receives face-to-face services and the client has been admitted to the program. Services may not be billed for the days the client is not present.
⇒ Board and Care costs are not included in the claiming rate (also §1840.312).
⇒ The day of admission may be billed but not the day of discharge.

Minimum Documentation Requirements:
(**See** also Chapter 1, "General Documentation Rules")

⇒ Date(s) of Service
⇒ Procedure Code
⇒ Written assessment upon admission that includes (LAC-DMH Policy 104.9):
  - health and psychiatric histories;
  - psychosocial skills;
  - social support skills;
  - current psychological, educational, vocational and other functional limitations;
  - medical needs, as reported; and
  - meal planning, shopping, and budgeting skills.
⇒ The notes shall address (LAC-DMH Policy 104.9):
  - Activities in which the client participated
  - Client's behaviors and staff intervention
  - Progress toward objectives or documentation of lack of progress
  - Involvement of family members if appropriate
  - Contact with other programs/agencies/treatment personnel involved with the client's treatment.
⇒ There shall be notes for all staff involved in the client's treatment.
⇒ For Crisis Residential and Transitional and Long-Term Residential services:
  - There shall be a note whenever a scheduled session takes place with the client.
  - There shall be a note indicating the activities in which the client participated.

Signature Requirements:
(See Chapter 1, "Signature Requirements.")

ADULT RESIDENTIAL TREATMENT SERVICES
(Transitional and Long Term)

Definition (§1810.203):

Rehabilitation services provided in a non-institutional residential setting which provide a therapeutic community including a range of activities and services for clients who would be at risk of hospitalization or other institutional placement if they were not in the residential treatment program. The service is available 24 hours a day, seven days a week.

Service Activities:

Services shall be consistent with §532 of Title 9, California Code of Regulations. Service activities may include Assessment, Plan Development, Therapy, Rehabilitation and Collateral (§1810.203).

NOTE:
- Not all of these activities need to be provided for the service to be billable.
- Medication Support Services shall be billed separately from Adult Residential Treatment Services [§1840.326(b)].

The codes for claiming are according to type of residential program. Please see "Guide to Procedure Codes" for the appropriate code(s), code modifiers, and place of service codes for:
- Transitional Residential - Transitional
- Transitional Residential - Long Term

Site and Contact Requirements (§1840.332):

There is a clearly established certified site for services although all services need not be delivered at that site. Services shall not be billable unless there is face-to-face contact on the day of service and the client has been admitted to the program.

Programs providing Adult Residential Treatment Services must be certified as a Social Rehabilitation Program by the State Department of Mental Health as either a Transitional Residential Treatment Program or a Long Term Residential Treatment Program. Facility capacity must be limited to a maximum of 16 beds.

In addition to Social Rehabilitation Program certification, programs providing Adult Residential Treatment Services must be licensed as a Social Rehabilitation Facility or Community Care Facility by the Department of Social Services or authorized to operate as a Mental Health Rehabilitation Center by the State Department of Mental Health.

Lockouts (§1840.362):

Adult Residential Treatment Services are not reimbursable on days when Crisis Residential Treatment Services, Inpatient Services, or Psychiatric Health Facility or Psychiatric Nursing Facility Services are reimbursed, except for the day of admission.

Providers may not allocate the same staff's time under the two cost centers of Adult Residential and Mental Health Services for the same period of time.

Frequency of Documentation:

At least a weekly summary and a separate note whenever a scheduled session takes place with the client.

Staffing Ratio and Staff Qualifications (§1840.354):

Staffing ratios and qualifications in Adult Residential Treatment Services shall be consistent with Title 9, §531 (see Appendix).

There shall be a clear audit trail of the number and identity of the persons who provide Adult Residential Treatment Services and function in other capacities.

CRISIS RESIDENTIAL TREATMENT SERVICES

Definition (§1810.208):

"Crisis Residential Treatment Service" means therapeutic or rehabilitative services provided in a non-institutional residential setting which provides a structured program for clients as an alternative to hospitalization for clients experiencing an acute psychiatric episode or crisis who do not present medical complications requiring nursing care. The service supports clients in their efforts to restore, maintain and apply interpersonal and independent living skills, and to access community support systems. The service is available 24 hours a day, seven days a week.

Service Activities:

Services shall be consistent with §532 of Title 9, CCR (see Appendix).

Service activities include assessment, plan development, therapy, rehabilitation, collateral, and crisis intervention (§1810.208).

NOTE:

- Not all of these activities need to be provided for the service to be billable.
- Medication Support Services shall be billed separately from Adult Residential Treatment Services [§1840.326(b)].

Site and Contact Requirements (§1840.334):

There is a clearly established certified site for services although all services need not be delivered at that site. Services shall not be billable unless there is face-to-face contact on the day of service and the client has been admitted to the program.

Programs shall have written procedures for accessing emergency psychiatric and health services on a 24-hour basis.

Programs providing Crisis Residential Treatment Services must be certified as a Social Rehabilitation Program (Short-Term Crisis Residential Treatment Program) by the State Department of Mental Health. Facility capacity must be limited to a maximum of 16 beds.

In addition to Social Rehabilitation Program certification, programs providing Crisis Residential Treatment Services must be licensed as a Social Rehabilitation Facility or Community Care Facility by the State Department of Social Services or authorized to operate as a Mental Health Rehabilitation Center by the State Department of Mental Health.

Lockouts (§1840.364):

Crisis Residential Treatment Services are not reimbursable on days when the following services are reimbursed, except for day of admission to Crisis Residential Treatment Services:

- Mental Health Service
- Day Treatment Intensive
- Day Rehabilitation
- Inpatient Services
- Psychiatric Health Facilities Services
- Psychiatric Nursing Facility Services
- Adult Residential Treatment Services
- Crisis Intervention
- Crisis Stabilization

Frequency of Documentation:

There shall be a daily note for each day the client is in the program (LAC-DMH Policy 104.9); (SDMH Contract, Exhibit A, Attachment 1, Appendix C).

Staffing Ratio and Staff Qualifications (§1840.356):

Staffing ratios and qualifications in Crisis Residential Treatment Services shall be consistent with CCR, Title 9, §531 (See Appendix).

PSYCHIATRIC HEALTH FACILITY

Definition (§1810.236):

A "Psychiatric Health Facility" is licensed by the State Department of Mental Health under the provisions of Chapter 9, Division 5 of Title 22 as providers of inpatient hospital services and will be governed by the provisions applicable to hospitals and psychiatric inpatient hospital services, except when specifically indicated in context.

Services (§1810.237):

Psychiatric Health Facility Services are therapeutic and/or rehabilitation services provided in a non-hospital 24-hour inpatient setting, on either a voluntary or involuntary basis. Services are provided to clients who need acute care and whose physical health needs can be met in an affiliated hospital or in outpatient settings. The determination for the need for acute care shall be made in accordance with §1820.205 (see Appendix item, "Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient Hospital Services") .

Site and Contact Requirements (§1840.340):

There is a clearly established certified site for services. Services shall not be billable unless there is face-to-face contact on the day of service and the client has been admitted to the program.

Programs providing Psychiatric Health Facility Services must be licensed as a Psychiatric Health Facility by the State Department of Mental Health under the provisions of Chapter 9, Division 5 of Title 22 (§1810.236).

Programs shall have written procedures for accessing emergency health services on a 24 hour basis.

Lockouts (§1840.370):

The following services are not reimbursable on days when Psychiatric Health Facility Services are reimbursed, except for day of admission to Psychiatric Health Facility Services:

- Adult Residential Treatment Services
- Crisis Residential Treatment Services
- Crisis Intervention
- Day Treatment Intensive
- Day Rehabilitation
- Inpatient Services
- Medication Support Services
- Mental Health Services
- Crisis Stabilization - Emergency Room
- Crisis Stabilization - Urgent Care
- Psychiatric Nursing Facility Services

Minimum Documentation Requirements:

(See also, Chapter 1, "General Documentation Rules", and "Minimum Documentation Requirements" at the beginning of this Chapter.)

Date of Service and shift
A description of service provided.
Interdisciplinary Treatment Plan within 72 hours following admissions (Saturdays, Sundays, and holidays excepted), consistent with requirements described in §77073 of Title 22, CCR, (See Appendix).

Frequency of Documentation:

A note on each shift

Staffing Ratios and Staff Qualifications (§1840.358):

Staffing ratios in Psychiatric Health Facility Services shall be consistent with §77061 of Title 22, CCR (see Appendix).

Staffing qualifications shall be consistent with Sections 77004, 77011.2, 77012, 77012.1, 77012.2, 77017, 77023, 77059-77069, 77079.1 and 77079.12, of Title 22, CCR (see Appendix).

A clear audit trail must be maintained for staff who function as Psychiatric Health Facility Services staff and in other capacities.

CHAPTER 6

Definitions

DEFINITIONS
(arranged alphabetically)

ACADEMIC EDUCATIONAL SERVICE
Non-Medi-Cal reimbursable educational activities in which the focus is on learning information for the purpose of furthering one's scholastic ability.

ADOLESCENT
A minor aged 12 through 18; adolescents receiving AB 3632 services are included through age 22, and in some instances may be up to age 25. This Client may participate in planning activities and sign his/her Client Care/Coordination Plan, at the discretion of the service provider and family. A minor, age 12 through 18 may consent to his/her own services, with the exception of medication, if s/he meets all of the criteria as specified on the "Consent of Minor" form.

ADULT RESIDENTIAL TREATMENT SERVICE (AdRes)
(See Chapter 5, *Regulations and Requirements for Services Based on Calendar Days, Adult Residential Services*)

ASSESSMENT
[See Chapter 2, *Regulations and Requirements for Services Based on Minutes of Staff Time (Mode 15), Service Definitions and Rules, Mental Health Services, Assessment (A)*]

BACHELOR'S DEGREE IN MENTAL HEALTH RELATED FIELD
A bachelor's degree in a mental health related field means that the service delivery staff person, in lieu of a license, has received a baccalaureate degree in a discipline that may include child development, child psychology, counseling and guidance, counseling psychology, early childhood education, human services, social psychology, social science, social welfare, social work, or sociology. Other disciplines may be approved by the local mental health director if she/he determines that such curriculums have mental health application.

BARRIERS TO REACHING GOALS
This is the second element on the Client Care/Coordination Plan (see also "Desired Outcomes/Long-Term Goals). A combination of the client's self-awareness and observations of service delivery staff may be the identified obstacles for the client to achieving his/her Long-Term Goals

BENEFICIARY (§1810.205)
Any person certified as eligible under the Medi-Cal Program according to Title 22, Section 51001.

CASE MANAGEMENT/BROKERAGE – See TARGETED CASE MANAGEMENT

CERTIFIED MENTAL HEALTH REHABILITATION PROGRAM
A certified provider where Medi-Cal services occur under the federal programs of Rehabilitation Option or Targeted Case Management.

CHILD
A minor under the age of 12 receiving services. This Client may participate in planning activities and sign his/her Client Care/Coordination Plan, at the discretion of the service provider and family. A minor under the age of 12 may never consent for their own services.

CLAIMING (§1840.100)
The process by which MHPs may obtain FFP (Federal Financial Participation) for the expenditures they have made for specialty mental health services to Medi-Cal clients.

CLIENT
The term most commonly used by the LAC-DMH when referring to a consumer of services, regardless of payer. .

CLIENT CARE/COORDINATION PLAN (CCCP)
(See Chapter 1, *Service, Documentation, and Reimbursement Basics, Client Care/Coordination Plan*)

CLINICAL RECORD/CHART
The case record for a client that documents all services delivered to a client within a Provider. It provides a record of services for clinical continuity of care and is the audit trail for all claims.

COLLATERAL (Col) (also see SIGNIFICANT SUPPORT PERSONS)
[See Chapter 2, *Regulations and Requirements for Services Based on Minutes of Staff Time (Mode 15), Service Definitions and Rules, Mental Health Services, Collateral*]

COORDINATION CYCLE DATE
For clients new to the system and those without open episodes, it is the date of admission, e.g., 05/14/04. For successive year it will be the first day of the month of intake, e.g., 05/01/05. For clients with open episodes anywhere within the system, it is the cycle date established by the current Coordinator/SFPR

COORDINATION PLAN – See CLIENT CARE/COORDINATION PLAN

COORDINATOR

Also known as the Single Fixed Point of Responsibility (SFPR). This person or team provides the primary point of coordination for a client, as identified in LAC-DMH's Information System (IS). The Coordinator is responsible for developing the Client Care/Coordination Plan with the Client and approving Client Care/Coordination Plans for any Mental Health Services, Day Treatment, Day Rehabilitation, and Adult Residential services proposed by any provider in the LAC-MHP system of care. Once established, a staff person or team remains a client's Coordinator/SFPR even when all episodes are closed or the client is not participating in services until the responsibility is transferred to another staff person.

CRISIS INTERVENTION (CI)

[See Chapter 2, *Regulations and Requirements for Services Based on Minutes of Staff Time (Mode 15), Service Definitions and Rules, Crisis Intervention*]

CRISIS RESIDENTIAL TREATMENT FACILITY (CrRes)

(See Chapter 5, *Regulations and Requirements for Services Based on Calendar Days, Crisis Residential Treatment Services*)

CRISIS STABILIZATION (CS)

[See Chapter 4, *Regulations and Requirements for Services Based on Blocks of Time (Mode 10), Medi-Cal Reimbursable Services, Hours of Time, Crisis Stabilization Services*]

CULTURAL COMPETENCE (§1810.211)

"Cultural Competence" means a set of congruent practice skills, behaviors, attitudes, and policies in a system, agency, or among persons providing services that enables that system, agency, or those persons providing services to work effectively in cross cultural situations.

CYCLE PERIOD

For services after the initial Client Care/Coordination Plan (CCCP), the cycle period is the timeframe for developing subsequent Client Care Plans. For CalWORKs, this includes not only the CCCP but also the CalWORKS Client Employment Plan. CalWORKS cycle periods are every three months; for Targeted Case Management (TCM) and Medication Support (Meds or MSS), the cycle period is annual. For all other services, the cycle period is every six months and annually. The Client Care/Coordination Plan must align with the cycle date (see Coordination Cycle Date).

Example of the cycle period for a client whose date of intake is 05/14/04:

- The initial CCCP is due at the time of or close to the completion of the intake assessment, but no later than 07/13/04 (60 days from the date of example above).
- For subsequent CCCPs:

  CalWorks – within the month prior to 8/1/04, 11/1/04, 2/1/05, and 5/1/05
  All services except Meds & TCM – within the month prior to 11/1/04 & 5/1/05
  All services including MSS and TCM – within the month prior to 05/1/05

DAY REHABILITATION (DR)
[See Chapter 4, *Regulations and Requirements for Services Based on Blocks of Time (Mode 10), Medi-Cal Reimbursable Services, Half or Full-Days of Time, Day Rehabilitation*]

DAY TREATMENT INTENSIVE (DTI)
[See Chapter 4, *Regulations and Requirements for Services Based on Blocks of Time (Mode 10), Medi-Cal Reimbursable Services, Half or Full-Days of Time, DayTreatment Intensive*]

DESIRED OUTCOME/LONG-TERM GOAL
This is the first element in the Client Care/Coordination Plan. In the words of the client and, for minors, the responsible adult, this is a statement of what the client wants to accomplish with the assistance of mental health services within the next 12 months.

DURATION OF SERVICE
The amount of time it takes to deliver the services, including travel and documentation.

EMERGENCY PSYCHIATRIC CONDITION (§1810.216)
A condition that meets the criteria in §1820.205 (Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient Hospital Services) and when the client with a condition, due to a mental disorder, is a danger to self or others, or immediately unable to provide for or utilize, food, shelter or clothing, and requires psychiatric inpatient hospital or psychiatric health facility services.

FACE-TO-FACE TIME
See “TYPES OF TIME” below.

FEE-FOR-SERVICE/MEDI-CAL
California’s Medicaid program that provides reimbursement for a broad array of health and limited mental health services provided to Clients who are eligible for Medi-Cal.

FREEDOM OF CHOICE
Local mental health programs shall inform Clients receiving services under the Rehabilitation Option, including parents or guardians of children/adolescents, verbally or in writing that:

A. Acceptance and participation in the mental health system is voluntary and shall not be considered a prerequisite for access to other community services;
B. They retain the right to access other Medi-Cal or Short-Doyle/Medi-Cal reimbursable services and have the right to request a change of provider and/or staff person/therapist/case manager.

FUNCTIONAL IMPAIRMENT
A dysfunction caused by a person’s mental illness in an important area of life functioning, such as living situation, daily activities, or social support.

GROUP (Gr)

[See Chapter 2, *Regulations and Requirements for Services Based on Minutes of Staff Time (Mode 15), Service Definitions and Rules, Mental Health Services, Group Service.*]

HEAD OF SERVICE (CCR, Title 9, §622)

Each provider shall have a head of service in conformance with one of the following staff categories recognized by the Los Angeles County Mental Health Plan.

Psychiatrist (CCR, Title 9 §623)
Psychiatrist means a person possessing a valid license as physician and surgeon from the Medical Board of California and evidence of completion of the required course of graduate psychiatric education as specified by the American Board of Psychiatry and Neurology in a program of training accredited by the American Medical Association or the American Osteopathic Association.

Psychologist (CCR, Title 9 §624)
Psychologist means a person possessing a valid license as a clinical psychologist granted by the Medical Board of California unless exempt or waivered under the provisions of Welfare and Institutions Code, Section 5751.2; and shall have two (2) years post-doctoral experience in a mental health setting.

Licensed Clinical Social Worker (CCR, Title 9 §625)
Social Worker means a person possessing a valid license as a clinical social worker granted by the California Board of Behavioral Science Examiners unless exempt or registered/waivered under the provisions of Welfare and Institutions Code, Section 5751.2; and shall have two (2) years post master's experience in a mental health setting.

Marriage & Family Therapist (CCR, Title 9 §626)
Marriage, Family, and Child Counselor means a person possessing a valid license as a marriage, family, and child counselor granted by the California Board of Behavioral Science Examiners; or who has been registered/waivered under the provisions of Welfare and Institutions Code, Section 5751.2; and shall have two (2) years post master's experience in a mental health setting.

Registered Nurse (CCR, Title 9 §627)
Registered Nurse means a person possessing a valid license to practice as a registered nurse granted by the California Board of Registered Nursing and a master's degree in psychiatric or public health nursing, and two years of nursing experience in a mental health setting. Additional post baccalaureate nursing experience in a mental health setting may be substituted on a year-for-year basis for the education requirement.

INTAKE PERIOD (LAC-DMH Policy No. 104.9)

Initial clinical evaluations must be completed within 60 days of intake for a new admission (no open episodes), or within 30 days when the client is being opened to a new service but has other open episodes.

INSTITUTION FOR MENTAL DISEASE (§1810.222.1)

A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental illness, including medical attention, nursing care, and related services.

LEGAL ENTITY (CCR, Title 9, §1840.100)

Each MHP and each of the corporations, partnerships, agencies, or individuals providing specialty mental health services under contract with the MHP, except that legal entity does not include individual or group providers, Fee-For-Service/Medi-Cal hospitals or psychiatric nursing facilities.

LICENSED CLINICAL SOCIAL WORKER (LCSW)

A person with a license to practice as a clinical social worker granted by the State Board of Behavioral Science Examiners. A licensed clinical social worker candidate who is registered or waivered may assume certain roles and responsibilities of a licensed clinician, within scope of practice; e.g., provide therapy and develop and sign Client Care/Coordination Plans. Registered/waivered staff may document in the clinical record without co-signatures.

LICENSED VOCATIONAL NURSE (LVN)

A person with a license to practice vocational nursing granted by the State Board of Vocational Nurse and Psychiatric Technician Examiners.

LOCAL MENTAL HEALTH PLAN (LMHP)

(See Mental Health Plan)

LOCKOUT (§1840.100)

A situation of circumstance under which Federal Financial Participation (FFP) is not available for a specific specialty mental health service.

MARRIAGE & FAMILY THERAPIST (MFT)

A person with a license to practice as a marriage & family therapist granted by the State Board of Behavioral Science Examiners. A licensed marriage & family therapist candidate who is registered or waivered may assume certain roles and responsibilities of a licensed clinician, within scope of practice; e.g., provide therapy and develop and sign Client Care/Coordination Plans. Registered/waivered staff may document in the clinical record without co-signatures.

MEDICAID

The federal and state program that provides federal reimbursement to states for some of the costs of medical care for the poor and disabled. The State Department of Health Services is the "single State agency" charged with administering the program. Reimbursement for eligible mental health services are processed to that agency through the State Department of Mental Health.

MEDI-CAL

California's Medicaid Program is called Medi-Cal.

MEDICAL NECESSITY

(See Chapter 1, *Service, Documentation, and Reimbursement Basics, Medi-Cal Medical Necessity*)

MEDICATION SUPPORT SERVICES (Meds or MSS)

[See **also** Chapter 2, *Regulations and Requirements for Services Based on Minutes of Staff Time (Mode 15), Service Definitions and Rules, Medication Support Services* **and** *A Guide to Procedure Codes, Medication Support – SD/MC & FFS*]

MENTAL HEALTH PLAN (MHP) (§1810.226)

"Mental Health Plan" means an entity which enters into an agreement with the State DMH to arrange for and/or provide specialty mental health services to beneficiaries (clients) in a county…A MHP may be a county, counties acting jointly or another governmental or nongovernmental entity. For our purposes the MHP or LMHP is Los Angeles County Department of Mental Health.

MENTAL HEALTH REHABILITATION SPECIALIST (CCR, Title 9 §630)

A mental health rehabilitation specialist is an individual who has a baccalaureate degree and four years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment. Up to two years of graduate professional education may be substituted for the experience requirement on a year-for-year basis; up to two years of post-associate arts clinical experience may be substituted for the required educational experience, in addition to the requirement of four years of experience in a mental health setting.

MENTAL HEALTH SERVICES (MHS)

[See Chapter 2, *Regulations and Requirements for Services Based on Minutes of Staff Time (Mode 15), Service Definitions and Rules, Mental Health Services*]

MONTH OF INTAKE SCHEDULE-COORDINATED SERVICES

The Month of Intake Schedule refers to specific time frames for the completion of the Coordination Plan for each Client receiving Mental Health Services, Day Treatment Intensive, Day Rehabilitation, Adult Residential Services, or Medication Support Services. The Month of Intake Schedule also refers to specific time frames for the completion of Client Care Plans for Mental Health Services, Day Treatment Intensive, Day Rehabilitation or Adult Residential Services. The due date for a Client Care Plan and Coordination Plan are based on the month of his/her intake. The Month of Intake Schedule revolves on the first day of the month of intake. The Month of Intake is the month the Client first receives any of the following services: Medication Support, Case Management/Brokerage, Mental Health, Day Treatment Intensive, Day Rehabilitation, or Adult Residential Services.

OCCUPATIONAL THERAPISTS
An Occupational Therapist is a graduate of an occupational therapy curriculum accredited jointly by the Council on Medical Education of the American Medical Association and the American Occupational Therapy Association, and who is registered or who is eligible for registration by the American Occupational Therapy Association.

OTHER TIME
See "TYPES OF TIME" below.

OUTPATIENT HOSPITAL SERVICES
Outpatient Hospital Services can provide case management and/or rehabilitative service providers as long as they:
1. Are licensed or formally approved as a hospital by an officially designated authority for State Standards setting:
2. Meet the requirements for participation in Medicare; and
3. Provide basic mental health services.

PERSONAL CARE SERVICES
These are non-Medi-Cal or Medicare reimbursable services provided to the Client which they cannot perform for themselves or which the service provider cannot teach the Client to perform for themselves.

PHARMACIST
A person registered to practice by the State Board of Pharmacy. This license allows only the delivery of Medication Support Services under the Rehab Option. However, a pharmacist's education and/or experience may qualify him/her for one of the other
Medi-Cal reimbursement staff categories.

PHYSICIAN
A person with a license to practice as a physician granted by the State Medical Board of California.

PLAN DEVELOPMENT (§1810.232)
"Plan Development" means a service activity that consists of the development of client plans, approval of client plans, and/or monitoring of a client's progress.

PROVIDER (§1810.235)

A person or entity who is licensed, certified, or otherwise recognized or authorized under state law governing the healing arts to provide specialty mental health services and who meets the standards for participation in the Medi-Cal program as described in CCR, Title 9, Chapter 11 and in Division 3, Subdivision 1 of Title 22. Provider includes licensed mental health professionals, clinics, hospital outpatient departments, certified day treatment facilities, certified residential treatment facilities, skilled nursing facilities, psychiatric health facilities, and hospitals. The MHP is a provider when direct services are provided to clients by employees of the MHP.

PSYCHIATRIC HEALTH FACILITY (PHF)

(See Chapter 5, *Regulations and Requirements for Services Based on Calendar Days, Psychiatric Health Facility, Definition*)

PSYCHIATRIC HEALTH FACILITY SERVICES

(See Chapter 5, *Regulations and Requirements for Services Based on Calendar Days, Psychiatric Health Facility, Services*)

PSYCHIATRIC NURSING FACILITY SERVICES (§1810.238)

Skilled nursing facility services as defined in Title 22, Section 51123, that include special treatment program services for mentally disordered persons as defined in Chapter 3, Division 5, Title 22, provided by an entity that is licensed as a skilled nursing facility by the State Department of Health Services and is certified by the department to provide special treatment program services.

PSYCHIATRIST

A Psychiatrist shall have a license to practice as a physician and surgeon granted by the Medical Board of California and show evidence of having completed the required course of graduate psychiatric education as specified by the American Board of Psychiatry and Neurology in a program training accredited by the Accreditation Council for Graduate Medical Education, the American Medical Association or the American Osteopathic Association.

PSYCHOLOGICAL TESTING (PsyT)

[See Chapter 2, *Regulations and Requirements for Services Based on Minutes of Staff Time (Mode 15), Service Definitions and Rules, Mental Health Services, Psychological Testing*]

PSYCHOLOGIST

A psychologist shall have obtained a license to practice as a clinical psychologist granted by the State Board of Psychology, Medical Board of California. A psychologist with a waiver may assume certain roles and responsibilities of a licensed clinician, within scope of practice; e.g., provide therapy and develop and sign Client Care/Coordination Plans. Registered/Waivered staff may document in the clinical record without co-signatures.

RECREATION
Non Medi-Cal reimbursable a;ctivities which have as their sole purpose relaxation, leisure, or entertainment.

REGISTERED NURSE
A nurse shall be licensed to practice as a registered nurse by the California Board of Registered Nursing.

REHABILITATION
[See Chapter 2, *Regulations and Requirements for Services Based on Minutes of Staff Time (Mode 15), Service Definitions and Rules, Rehabilitation*]

RENDERING PROVIDER
This is the staff who provided or was involved in the provision of service and wrote the progress note. The claim for the service must be submitted under this person's name.

SERVICE PLAN – See CLIENT CARE/COORDINATION PLAN

SIGNIFICANT SUPPORT PERSON (§1810.246.1)
(Also see COLLATERAL)
"Significant support persons" means persons, in the opinion of the client or the person providing the service who have or could have a significant role in the successful outcome of treatment, including, but not limited to the parents or legal guardian of a client who is a minor; the legal representative of a client who is not a minor; a person living in the same household as the client; the client's spouse, and relatives of the client.

SINGLE FIXED POINT OF RESPONSIBILITY (SFPR)
Alternate language for "Coordinator" in Los Angeles County.

SOCIALIZATION
(See Chapter 4, *Regulations and Requirements for Services Based on Blocks of Time (Mode 10) County General Fund Reimbursable Services, 4-hour Blocks of Time, Socialization Services*)

SPECIALTY MENTAL HEALTH SERVICES (§1810.247)
"Specialty Mental Health Services" means:

a. Rehabilitative Services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential treatment services, and psychiatric health facility services;
b. Psychiatric Inpatient Hospital Services;
c. Targeted Case Management;
d. Psychiatric Services;
e. Psychologist Services
f. EPSDT Supplemental Specialty Mental Health Services; and
g. Psychiatric Nursing Facility Services.

STANDARD REASON FOR DISALLOWANCES

State Department of Mental Health documents which list all of the standard reasons to take disallowances for non-compliance under the Medi-Cal program, e.g., attachments to SDMH Information Notices regarding audits, such as "Reasons for Recoupment."

STUDENT

A person, paid or unpaid, undergraduate or graduate, delivering services in the LA County mental health system of care under a formal agreement with the County Department of Mental Health covering the student experience. The documentation of all client services provided by a student must be co-signed by the student's supervisor.

TARGETED CASE MANAGEMENT (TCM)

[See Chapter 2, *Regulations and Requirements for Services Based on Minutes of Staff Time (Mode 15), Service Definitions and Rules, Targeted Case Management*]

THERAPY (CCR, Title 9, Division 1, §543)

A goal directed clinical intervention with a client which focuses on the mental health needs of the client.

(See **also** Chapter 2, *Regulations and Requirements for Services Based on Minutes of Staff Time (Mode 15), Mental Health Services, Therapy* for additional information and for the State regulation definition.)

TOTAL TIME

See "TYPES OF TIME" below.

TWO YEARS EXPERIENCE PROVIDING SERVICES IN THE MENTAL HEALTH FIELD (PAID or UNPAID)

The local mental health director shall be responsible for describing or approving specific criteria used to determine the adequacy of a staff person's work experiences providing services in the mental health field, paid or unpaid, and the applicability of those skills and experiences in the provision of services to Clients.

TYPES OF TIME

- **Face-to-Face Time:** This time is defined very literally, that is, the time a client is visually in the presence of and interacting in some way with staff. In many situations, "Face-to-face Time" will be zero with all the service time recorded and reported as "Other Time".
- **Other Time:** This includes non-face-to-face contacts (such as phone calls) with a client or his/her collaterals, time performing reimbursable non-contact services (such as writing a discharge summary), and documentation and travel time.
- **Total Time:** This is the time on which the Department is reimbursed for outpatient services. It is the total of "Face-to-face Time" and "Other Time". For the Rendering Provider of non-group services, the computer calculates this time by totaling the entered "Face-to-face Time" and "Other Time". The Rendering Provider of group services records in the record and

reports only "Total Time". All other staff participants of a service, whether group or non-group, record and report "Total Time" only.

URGENT CONDITION (§1810.253)

"Urgent Condition" means a situation experienced by a client that, without timely intervention, is certain to result in an immediate emergency psychiatric condition.

VOCATIONAL SERVICES

(See Chapter 4, *Regulations and Requirements for Services Based on Blocks of Time (Mode 10), County General Fund Reimburse able Services, 4-hour Blocks of Time, Vocational Services*)

WAIVERED/REGISTERED PROFESSIONAL (§1810.254)

An individual who has a waiver of psychologist licensure issued by the State Department of Mental Health or has registered with the applicable state licensing authority to obtain supervised clinical hours for Marriage, Family, and Child Counselor or Clinical Social Worker licensure..

WINDOW PERIOD

The Window Period refers to the specific timelines for the review and update of the Client Care/Coordination Plan. One month window periods occur the month prior to the Coordination Cycle Date and the month prior to its six-month anniversary. A Plan signed any time during the window period shall be effective for the subsequent period.

APPENDIX

Chapter 1

Website addresses

Examples of Medi-Cal Reimbursable and Non-Reimbursable Vocational, Educational, Recreational and Socialization Activities

LAC-DMH memo, December 1, 2003, “Documentation of Mental Health Services”

Progress Note Samples

Medi-Cal Included Diagnoses

Website Addresses

- **State DMH Letters and Notices**: **www.dmh.ca.gov/DMHDocs/**
  Click on DMH Letters or DMH Notices. The Letters and Notices are referenced by a number. The first two numbers are the year of issue; the number after the dash is the numerical order in which the document was issued in that year.

- **California Code of Regulations:** At **www.dmh.ca.gov/DMHDocs/**, click on Laws & Regulations in the contents column on the left side of the web page. At the Office of Regulations home page, click on Laws and Regulations Publication in the left hand content column. Scroll to the bottom of the page and click on California Code of Regulations on the right. In the box "Query Templates," click on "Go to a Specific Section" and follow the directions. The section you are seeking will be displayed. If you follow a short-cut by going directly to the Codes, you may not always locate the code section(s) you are seeking.

- **Code of Federal Regulations (CFR):** You may search for specific CFR items at the website, **http://www.gpoaccess.gov/cfr/**.

- **LAC-DMH Procedure Codes Guide**:
  From the Internet:
  The main LAC-DMH web page is **http://dmh.lacounty.gov** Click "Provider Tools" (on the left side of the screen), then "Integrated System". For the most recent "Procedure Codes Guide", click on "Procedure Codes Manual" found on the front page.

  From the Intranet:
  At the LAC-DMH Intranet page, click on the top tab titled "Hipaa". For the most recent "Procedure Codes Guide", click on "Procedure Codes Manual" found on the front page.

- **LAC-DMH SC/MC Organizational Provider's Manual**
  From the Internet:
  The main LAC-DMH web page is **http://dmh.lacounty.gov**. Click "Provider Tools" (on the left side of the screen), then "Agency Administration". Organizational Provider's Manual is listed in the center of the screen under "Provider Manuals"

Examples of Medi-Cal Reimbursable and Non-Reimbursable
Vocational, Educational, Recreational and Socialization Activities

Vocational Examples:

- Assisting the client to consider how the boss' criticism affects him/her and strategies for handling the situation **is** reimbursable no matter where the service is delivered.
- Visiting a client's job site to teach him/her a job skill **is not** reimbursable.
- Responding to the employer's call for assistance when the client is in tears at work because they are having trouble learning a new cash register **is** reimbursable if the focus of the intervention is assisting the client to decrease their anxiety enough to concentrate on the task of learning the new skill.
- Providing hands-on technical assistance to the client regarding the new cash register **is not** reimbursable.

Educational Examples:

- Sitting with a client in a community college class the first three times the client attends and debriefing the experience afterward **is** reimbursable.
- Assisting the client with their homework **is not** reimbursable.
- Assisting the client with the arithmetic necessary to help him/her manage their household budget **is** reimbursable.
- Teaching a class in remedial English **is not** reimbursable.
- Assisting a client to find tutorial help in English **is** reimbursable.
- Teaching a typing class on site at an adult residential treatment program in preparation for entry into a formal job training program **is not** reimbursable.
- Helping the individual with typing skills while he/she is working on a newsletter **is** reimbursable.

Recreational Examples:

- Helping clients improve their communication skills during a recreational activity **is** reimbursable.
- Playing basketball with clients or teaching them how to lift weights so that they do not injure themselves **is not** reimbursable.

Socialization Examples:

- Playing cards or any other games with a client or group of clients **is not** reimbursable.
- Helping the client learn better social skills so he/she will be better able to interact with people **is** reimbursable.

MH 515
Revised 10/15/03

PROGRESS NOTES

Date, Service, Procedure Code, *Hrs./Minutes	♦ Services submitted for SD/MC reimbursement have been determined to be appropriate and medically necessary. ♦ Refer to Medication Log for specific medication information when "medications prescribed", "medication renewed", or "medications administered" is noted on this form.
	Documentation of Out-of-Sequence/Late Entries
1/10/05	Upon request of client, I made a telephone call to Bill's Board and Care Home to make an
TCM – "PC"	appointment for the client to meet with Bill on Thursday, 1/12/05, at 10:00 a.m. I gave the client a
0/:20	sheet of paper with the name of the B&C home, address, and Bill's name, along with the appointment
	date and time. *Signature/Discipline*
① 1/5/05	④ Note written on 1/10/05. ⑤ Talked with client about his anxiety regarding living in a board and
② I – "PC" ③	care home. ⑥Client remains ambivalent and, as yet, has not taken any actions to contact any
:20/:15	residential facility. *Signature/Discipline*

1/16/05	Client kept his appointment at the board and care home. We talked about his fears of living away from
I – "PC"	his parents. The client liked the home, and although he is anxious about the move, he is feeling he
⑦1:15/:10	would like to live there. Supported client for keeping his appointment and for being willing to make
	this difficult decision. Encouraged client to talk with parents about this before our next appointment on
	1/22/05, at 2:00 p.m. *Signature/Discipline*
	Explanations
	① The service date is placed in the left column of the note.
	② Include the type of service (I=individual, Gr=Group, Col=Collateral, PsyT=Psych Testing,
	CC=Case Conference; TCM=Targeted Case Management; Meds or MSS=Med Support)
	③ "PC" is used in this example instead of an actual **P**rocedure **C**ode. In an actual note, use the
	appropriate procedure code.
	④ If a note is written out-of-sequence, it is considered a late entry. The date on which the note was
	written should appear at the beginning of the note. ⑤ Staff must state the intervention he/she
	attempted or accomplished toward the client's goals/milestones.
	⑥ This note also includes the client's response/progress toward his goals/milestones.
	⑦ Note the time should be written in hr:minutes. In this example the staff person spent 1 hour 15
	minutes face-to-face time and 10 minutes other time which includes travel and documentation. The
	computer calculates the total time of 85 minutes that will be claimed.

***All travel and documentation time must be associated with the activity.**

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name: **Doe, John** **MIS#:** **0000000**

Agency: **Headquarters** **Provider #:** **XXXX**

Los Angeles County – Department of Mental Health

MH 515
Revised 10/15/03

PROGRESS NOTES

Date, Service, Procedure Code, *Hrs./Minutes	♦ Services submitted for SD/MC reimbursement have been determined to be appropriate and medically necessary. ♦ Refer to Medication Log for specific medication information when "medications prescribed", "medication renewed", or "medications administered" is noted on this form.
	Documentation of Non-Group Contacts Involving More than One Staff
① 2/1/2005	Client's child's case manager, ⑤ Susie Smith, MSW, participated in session. ⑥ Ms. Smith shared
② I – "PC" ③	her observed behavior of the child in the classroom; how the behavior was handled and the child's
④ :55/:15	response. ⑦ I talked with this client about her handling of similar behaviors and the problems/feelings
:55 (SS)	she has that keep her from modifying her interactions with her child. (Additional information re
	interventions and client response, as appropriate.) ⑧ **one** *Signature/Discipline*
	Explanations
	① The date in the left column is the service date.
	② The type of service (I=individual, Gr=Group, Col=Collateral, PsyT=Psych Testing, CC=Case
	Conference; TCM=Targeted Case Management; Meds or MSS=Med Support) must be indicated.
	③ "PC" was used in this sample instead of an actual procedure code. In an actual note, the
	appropriate procedure code, under which services were claimed, would be used.
	④ When more than one staff are involved in the contact, the time spent, including travel and
	documentation, for each must be noted in the left column. The rendering provider must break out the
	face-to-face and "other" time. The second staff person only notes total time. Place the initials of the
	second staff person next to his/her total time. In this example the rendering staff person spent 55
	minutes face-to-face time and 15 minutes other time. The second staff person spent a total time of 55
	minutes. The initials of the second staff person are noted next to her claimed time.
	⑤ The name of the second staff person must be included in the note.
	⑥ With the exception of a co-leader in a group, a statement of justification/contribution is required
	for the second staff person involved in the contact.
	⑦ The primary staff must state the interventions he/she attempted or accomplished toward the
	client's goals/milestones.
	⑧ Even though two staff participated in this contact, only the rendering provider signs the note.

***All travel and documentation time must be associated with the activity.**

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name: **Doe, John** **MIS#:** **0000000**

Agency: **Headquarters** **Provider #:** **XXXX**

Los Angeles County – Department of Mental Health

MEDI-CAL INCLUDED DIAGNOSIS

295.10	Schizophrenia, disorganized type	302.3	Tranvestic Fetishism
295.20	Schizophrenia, catatonic type	302.4	Exhibitionism
295.30	Schizophrenia, paranoid type	302.6	Gender identity in child/NOS
295.40	Schizophreniform disorder	302.81	Fetishism
295.60	Schizophrenia, residual type	302.82	Voyeurism
295.70	Schizoaffective disorder	302.83	Sexual masochism
295.90	Schizophrenia, undiff type	302.84	Sexual sadism
296.00	Bipolar disorder, single manic epis unspec	302.85	Gender identity disorder in adults or adolecents
296.01-.06	Bipolar I disorders	302.89	Frotteurism
296.20-.26	Major depressive disorders, single episode	302.9	Paraphilia/Sexual disorder NOS
296.30-.36	Major depressive disorders, recurrent	307.1	Anorexia nervosa
296.40	Bipolar I disorder, most recent epis hypomanic	307.3	Stereotypic movement disorder
296.40-.46	Bipolar I disorder, most recent epis manic	307.50	Eating disorder NOS
296.50-.56	Bipolar I disorder, most recent epis depressed	307.51	Bulimia nervosa
296.60-.66	Bipolar I disorder, most recent epis mixed	307.52	Pica
296.7	Bipolar I disorder, most recent epis unspec	307.53	Rumination disorder
296.80	Bipolar disorder NOS	307.59	Feeding disorders of infancy or early childhood
296.89	Bipolar II disorder	307.6	Enuresis (not due to medical condition)
296.90	Mood disorder NOS	307.7	Encopresis without constipation/incontinence
297.1	Delusional disorder	307.80	Pain disorder assoc with psychological factor
297.3	Shared psychotic disorder	307.89	Pain disorder assoc with psych & medical condition
298.8	Brief psychotic disorder	308.3	Acute stress disorder
298.9	Psychotic disorder NOS	309.0	Adjustment disorder with depressed mood
299.10	Childhood disintegrative disorder	309.21	Separation anxiety
299.80	Asperger's disorder/Retts disorder	309.24	Adjustment disorder with anxiety
299.80	Pervasive developmental disorder NOS	309.28	Adjustment disorder mixed mood
300.00	Anxiety disorder NOS	309.3	Adjustment disorder with conduct disturbance
300.01	Panic disorder without agoraphobia	309.4	Adjustment disorder mixed emotion & conduct
300.02	Generalized anxiety disorder	309.81	Post traumatic stress disorder
300.11	Conversion disorder	309.9	Adjustment disorder unspecified
300.12-.15	Dissociative disorders	311	Depressive disorder NOS
300.16	Factitious disorder, predom psychological	312.30	Impulse control disorder NOS
300.19	Factitious disorder, combined, physical, NOS	312.31	Pathological gambling
300.21	Panic disorder with agoraphobia	312.32	Kleptomania
300.22	Agoraphobia without history of panic disorder	312.33	Pyromania
300.23	Social phobia	312.34	Intermittent explosive disorder
300.29	Specific phobia	312.39	Trichotillomania
300.3	Obsessive compulsive disorder	312.8	Conduct disorder
300.4	Dysthymic disorder	312.9	Disruptive disorder
300.6	Depersonalization disorder	313.23	Selective mutism
300.7	Body dysmorphic disorder/hypochondrias	313.81	Oppositional defiant disorder
300.81	Somatization disorder/Somatoform disorder	313.82	Identity problem
301.0	Paranoid personality disorder	313.89	Reactive attachment disorder
301.13	Cyclothymic disorder	313.9	Disorder of infancy, child/adol NOS
301.20	Schizoid personality disorder	314.00	Attention deficit/hyperactive disorder, inattentive
301.22	Schizotypal personality disorder	314.01	Atten deficit/hyper dis, hyper, impulse, combined
301.4	Obsessive compulsive personality disorder	314.9	Attention Deficit/hyperactivity disorder, NOS
301.50	HistrIonic personality disorder	332.1	Neuroleptic induced Parkinsonism
301.6	Dependent personality disorder	333.1	Medication induced postural tremor
301.81	Narcissistic personality disorder	333.7	Neuroleptic induced acute dystonia
301.82	Avoidant personality disorder	333.82	Neuroleptic induced tardive dyskinesia
301.83	Borderline personality disorder	333.90	Medication induced movement disorder NOS
301.9	Personality disorder NOS	333.92	Neuroleptic Malignant syndrome
302.2	Pedophilia	333.99	Neuroleptic induced acute akathisia
		787.6	Encopresis with constipation/incontinence

Revised 09/24/2004

Chapter 2

"Documentation for Services Based on Minutes of Time"

Quality Improvement Communiqué No. 4, December 13, 1993 (updated March 18, 2002)

Documentations for Services Based on Minutes of Time

Two Staff Provide Different Services in a Single Contact

Example 1: A physician and a nurse participate in a single contact, but provide different services and document their services separately – the physician prescribes a medication and the nurse administers the medication; two Medication Support Services claims should be documented and submitted.

Example 2: a physician and a case manager participate in a single Medication Support Service – the physician prescribes a medication and the case manager facilitates (language or cultural) their interaction and the client's access to MSS; the physician would claim a MSS and the case manager a TCM.

Two Staff Provide Group Services

Example 1: A service is provided by two staff to a group of five Medi-Cal eligible clients and two who are not. The reimbursable service (including direct service, travel time, plan development, and documentation) lasts 1 hour and 40 minutes for the Rendering Provider and one hour for the second staff person. The note must document the entire service, including the intervention contributions of each staff present. The note begins with language similar to "Co-led service with Suzie Smith, MSW intern." (The name of the staff his/her title are required elements.) Each staff person's total time, including the Rendering Provider, is the only time that needs to be documented. The computer will total the time of both staff (two hours and 20 minutes or 140 minutes) and divide that time by 7. Twenty minutes will be claimed to Medi-Cal for 5 clients and 20 minutes each for the two non-Medi-Cal clients to their appropriate payer source.

Example 2: A group of four clients and seven collaterals meet with two staff. Two clients are not present at this group session, but are represented by collaterals making six the number of clients present or represented. The group meets with the Rendering Provider for 1 hour and 30 minutes; the Rendering Provider documents in all six records for an additional 30 minutes. The second staff is present for only one hour of the group. All clients are listed on the Group Service Log, including the two not present. The Rendering Provider claims 2 hours of time and the second staff one hour. The computer total these times to 180 minutes and claims 30 minutes (180 divided by 6) to each client.

Quality Improvement Communique
December 13, 1993 No. 4
Standards and Records, Quality and Outcome Bureau
Office of the Medical Director, Department of Mental Health

This issue of the Quality Improvement Communique is devoted to the Los Angeles County application of the State's Rehab Option Bulletin dated August 20, 1993, Vol. 1, No. 3. In order to minimize confusion and ensure Los Angeles County applications of State DMH information are joined together, the County has, with the permission of the State, intertwined its comments into the State's Bulletin. Los Angeles County comments are in italics; text not applicable to the County is struck out.

STATE DEPT. MENTAL HEALTH

REHAB OPTION BULLETIN

August 20, 1993 Vol. 1, No. 3

The final authority on all matters related to the Rehabilitation Option is the Short-Doyle/Medi-Cal Manual for the Rehabilitation Option and Targeted Case Management issued with DMH Letter 93-09.

This rehab option bulletin provides responses and clarification to questions raised during statewide training on coordinated services and the Rehab Option in April, May, June 1993. Questions and concerns raised since implementation of the Rehab Option and Coordinated Services began July 1, 1993 are also addressed.

3.1 When providing Crisis Intervention, can you bill for services on the phone?

Yes, *if LA County DMH has approved your use of Crisis Intervention Service Function Codes*. Crisis Intervention Services may be either face to face or by telephone with the Individual or significant support person. *The situation must meet the definition of Crisis Intervention and documentation must meet all the standards in the Manual including indication* that the acuity of the individual or situation justifies Crisis Intervention. (SD/MC Rehab Option Manual, Pages 2-29 and 4-36).

3.2 If the physician goes out into the community on a crisis call, can you bill for a crisis?

Yes. Crisis Intervention could be billed assuming the ~~notes~~ *documentation meets all the requirements in the State Manual including* that the acuity of the individual or situation justifies Crisis Intervention. (SD/MC Rehab Option Manual, Page 2-29 *and 4-36*). Please note that if *any portion of* the service the physician provides is Medication Support, *the time spent providing medication support should be claimed to* that service function ~~would be billed~~. *For example, a physician goes with another staff person on a crisis call. Three hours lapse from the time they leave their work location to the time they both return from the crisis call. During the call, the physician spent 30 minutes on medication related issues (discussing, prescribing, &/or administering meds). In one claim, supported by a medication note, the physician would claim 30 minutes of Medication Support Services (Meds). In a second claim, supported by the Crisis Intervention note indicating the time of both staff, the non-physician would report 3 hrs of Crisis Intervention and the physician would report 2 hr, 30 min. (In the left column of the Progress Notes form, the time of these two staff providing Crisis Intervention would be recorded as 3:00/2:30.) The physician could claim all of his/her time as Crisis Intervention, but Meds does reimburse at a higher rate.*

3.3 A crisis worker talks to a board and care operator regarding Medi-Cal eligible client at the home. The board and care operator tells the crisis worker that the client is having a crisis. The crisis worker goes there and things are calm. Can you bill Crisis Intervention?

Yes, Crisis Intervention may be billed for staff time if *documentation of the caller's information indicates a crisis existed at the time of the call.* ~~your best information was that it was a crisis and there is documentation to that effect~~.

BREAK

3.17 The following question clarifies question 2.11 in Rehab Option Bulletin No. 2.

Vocational Services (Mode 10, Service Function 30-39), and Socialization (Mode 10, Service Function 40-49) are reportable to CDS and CR/DC, and are counted in 4 hour increments as follows:

Less than or equal to 4 hours = 1 block of services
Greater than 4 and up to 8 hours = 2 blocks of services

Chapter 3

California Code of Regulations (CCR), Title 9, Chapter 11, §1850.210

TITLE 9. Rehabilitative And Developmental Services
Division 1. Department of Mental Health
Chapter 11. Medi-Cal Specialty Mental Health Services
Subchapter 5. Problem Resolution Processes
§1850.210. Fair Hearing and Notice of Action.

§1850.210. Fair Hearing and Notice of Action.

(a) The MHP shall provide a beneficiary of the MHP with a Notice of Action when the MHP acts to deny an MHP payment authorization request from a provider for a specialty mental health service to the beneficiary. Notice in response to an initial request from a provider shall be provided in accordance with this subsection. Notice in response to a request for continuation of a specialty mental health service shall be provided in accordance with Title 22, Section 51014.1. The Notice of Action under this subsection shall not be required in the following situations:
(1) The denial is a denial of a request for MHP payment authorization for a specialty mental health service that has already been provided to the beneficiary.
(2) The denial is a non-binding verbal description to a provider of the specialty mental health services which may be approved by the MHP.

(b) The MHP of the beneficiary shall provide the beneficiary with a Notice of Action when the MHP defers action on an MHP payment authorization request from a provider for a specialty mental health service to the beneficiary. The Notice of Action shall be delayed for 30 calendar days to allow the provider of the specialty mental health service time to submit the additional information requested by the MHP and to allow time for the MHP to make a decision. If, after 30 calendar days from the MHP's receipt of the MHP payment authorization request, the provider has not complied with the MHP's request for additional information, the MHP shall provide the beneficiary a notice of action to deny the service pursuant to subdivision (a). If, within that 30 day period, the provider does comply, the MHP shall take appropriate action on the MHP payment authorization request as supplemented by the additional information, including providing a Notice of Action to the beneficiary if the service is denied or modified or if the MHP defers action on the MHP payment authorization request for an additional period of time. The Notice of Action under this subsection shall not be required when the MHP defers action on an MHP payment authorization request for a specialty mental health service that has already been provided to the beneficiary.

(c) The MHP shall provide a beneficiary of the MHP with a Notice of Action when the MHP modifies an MHP payment authorization request from a provider for a specialty mental health service to the beneficiary. Notice in response to an initial request from a provider shall be provided in accordance with Title 22, Section 51014.1. The Notice of Action pursuant to this subsection shall not be required when the MHP modifies the duration of any approved specialty mental health services as long as the MHP provides an opportunity for the provider to request MHP payment authorization of additional specialty mental health services before the end of the approved duration of services. The Notice of Action under this subsection shall not be required when the MHP modifies

an MHP payment authorization request for a specialty mental health service that has already been provided to the beneficiary.

(d) The written Notice of Action issued pursuant to subsections (a), (b), or (c) shall be deposited with the United States postal service in time for pick-up no later than the third working day after the action and shall specify:
(1) The action taken by the MHP.
(2) The reason for the action taken.
(3) A citation of the specific regulations or MHP payment authorization procedures supporting the action.
(4) The beneficiary's right to a fair hearing, including:
(A) The method by which a hearing may be obtained.
(B) That the beneficiary may be either:
1. Self-represented.
2. Represented by an authorized third party such as legal counsel, relative, friend or any other person.
(C) An explanation of the circumstances under which a specialty mental health service will be continued if a fair hearing is requested.
(D) The time limits for requesting fair hearing.

(e) The fair hearings under this section shall be administered by the State Department of Health Services.

(f) For the purpose of this section, each reference to Medi-Cal managed care plan in Title 22, Section 50114.1, shall mean the MHP.

(g) For the purposes of this section, “mental service” as cited in Title 22, Section 51014.1, shall mean those specialty mental health services that are subject to prior authorization by an MHP pursuant to subchapters 2 and 3.

(h) The provisions of this section do not apply to the decisions of providers including the MHP serving beneficiaries when prior authorization of the service by the MHP's authorization procedures is not a condition of payment to the provider for the specialty mental health service.

(i) When a Notice of Action would not be required under subsections (a), (b), or (c), the MHP of the beneficiary shall provide a beneficiary with Notice of Action under this subsection when the MHP or its providers determine that the medical necessity criteria in Section 1830.205(b)(1), (b)(2) or (b)(3)(C) or Section 1830.210(a) have not been met and that the beneficiary is, therefore, not entitled to any specialty mental health services from the MHP. The Notice of Action under this subsection, shall, at the election of the MHP, be hand delivered to the beneficiary on the date of the action or mailed to the beneficiary in accordance with subsection (d) and shall specify:
(1) The reason the mental necessity criteria was not met.
(2) The beneficiary's options for obtaining care outside the MHP, if applicable.
(3) The beneficiary's right to request a second opinion on the determination.

(4) The beneficiary's right to file a complaint or grievance with the MHP.
(5) The beneficiary's right to a fair hearing, including:
(A) The method by which a hearing may be obtained.
(B) That the beneficiary may be either:
1. Self-represented.
2. Represented by an authorized third party such as legal counsel, relative, friend or any other person.
(C) The time limits for requesting fair hearing.

NOTE
Authority cited: Section 14684, Welfare and Institutions Code. Reference: Section 14684, Welfare and Institutions Code.

HISTORY
1. New section filed 10-31-97 as an emergency; operative 11-1-97 (Register 97, No. 44). A Certificate of Compliance must be transmitted to OAL by 3-2-98 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 3-2-98 as an emergency; operative 3-2-98 (Register 98, No. 10). A Certificate of Compliance must be transmitted to OAL by 6-30-98 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 6-17-98 as an emergency; operative 6-30-98 (Register 98, No. 25). Pursuant to Chapter 324 (Statutes of 1998) Item 4440-103-0001(4), a Certificate of Compliance must be transmitted to OAL by 7-1-99 or emergency language will be repealed by operation of law on the following day.
4. Editorial correction of History 3 (Register 98, No. 39).
5. Editorial correction extending Certificate of Compliance date to 7-1-2001 pursuant to Chapter 50 (Statutes of 1999) Item 4440-103-0001(4) (Register 99, No. 33).
6. Editorial correction of History 5 (Register 2000, No. 42).

Chapter 4

"Staffing Requirements for Day Treatment Programs"

Quality Improvement Communiqué No. 4, December 13, 1993 (updated March 18, 2002) See Appendix Chapter 2.

STAFFING REQUIREMENTS FOR DAY TREATMENT PROGRAMS

Day Treatment Intensive (DTI)

At a minimum there must be an average ratio of at least one person from the following list providing DTI services to **8** clients in attendance during the period the program is open.

DTI programs serving more than **12** clients shall include at least one person from each of the two following staff categories:

- Physicians
- Psychologists or related waivered/registered professionals
- Licensed Clinical Social Workers or related waivered/registered professionals
- Marriage, Family and Child Counselors (MFT's) or related waivered/registered professionals
- Registered Nurses
- Licensed Vocational Nurses
- Psychiatric Technicians
- Occupational Therapists
- Mental Health Rehabilitation Specialists as defined in §630.

Day Rehabilitation (DR)

At a minimum there must be an average ratio of at least one person from the following list providing DR services to **10** clients in attendance during the period the program is open:

- Physicians
- Psychologists or related waivered/registered professionals
- Licensed Clinical Social Workers or related waivered/registered professionals
- Marriage, Family and Child Counselors (MFT's) or related waivered/registered professionals
- Registered Nurses
- Licensed Vocational Nurses
- Psychiatric Technicians
- Occupational Therapists
- Mental Health Rehabilitation Specialists as defined in §630.

Persons providing services in DR programs serving more than **12** clients shall include at least two of the following:

- Physicians
- Psychologists or related waivered/registered professionals
- Licensed Clinical Social Workers or related waivered/registered professionals
- Marriage, Family and Child Counselors (MFT's) or related waivered/registered professionals
- Registered Nurses
- Licensed Vocational Nurses
- Psychiatric Technicians
- Mental Health Rehabilitation Specialists as defined in §630.

Chapter 5

California Code of Regulations (CCR), Title 9, §531

CCR, Title 9, §532

CCR, Title 9, §1820.205

CCR, Title 22, §77073

CCR, Title 22, §77061

CCR, Title 22, §77004, §77011.2, §77012, §77012.1, §77012.2, §77017, §77023, §77059-77069 (§77061 in this series is found listed above), §77079.1, and §77079.12

TITLE 9. Rehabilitative And Developmental Services
Division 1. Department of Mental Health
Chapter 3. Community Mental Health Services Under the Short-Doyle Act
Article 3.5. Standards for the Certification of Social Rehabilitation Programs
§531. Program Standards and Requirements.

§531. Program Standards and Requirements.

(a) To be certified as a Short-Term Crisis Residential Treatment Program, a program shall provide:

(1) Services as specified in either subsection (e) or (f) of section 541 as an alternate to hospitalization for individuals experiencing an acute psychiatric episode or crisis. The planned length of stay in the program shall be in accordance with the client's assessed needs, but not to exceed thirty (30) days, unless circumstances require a longer length of stay to ensure successful completion of the treatment plan and appropriate referral. The reasons for a length of stay beyond thirty (30) days shall be documented in the client's case record. Under no circumstances may the length of stay exceed three (3) months.

(2) Scheduling of staff which provides for at least two (2) staff members to be on duty 24 hours a day, seven (7) days per week. If program design results in some clients not being in the facility during specific hours of the day, scheduling adjustments may be made so that coverage is consistent with and related to the number and needs of clients in the facility. During the night time hours, when clients are sleeping, only one of the two on duty staff members need be awake, providing the program does not accept admissions at that time. There shall be a staffing ratio of at least one (1) full-time equivalent direct service staff for each 1.6 clients served.

(b) To be certified as a Transitional Residential Treatment Program, a program shall provide:

(1) Services as specified in either subsection (h) or (i) of section 541 which shall provide a therapeutic environment in which clients are supported in their efforts to acquire and apply interpersonal and independent living skills. The program shall also assist the client in developing a personal community support system to substitute for the program's supportive environment and to minimize the risk of hospitalization and enhance the capability for independent living upon discharge from the program. The planned length of stay in the program shall be in accordance with the client's assessed need, but not to exceed one (1) year; however, a length of stay not exceeding a maximum total of 18 months is permitted to ensure successful completion of the treatment plan and appropriate referral. The reasons for a length of stay beyond one (1) year shall be documented in the client's case record.

(2) Greater number of staff shall be present during times when there are greater numbers of clients in programmed activities. Staff schedules shall be determined by the program based on the number of clients in the program during specific hours of the day, level of care provided by the program, and the range of services provided within the facility.

At least one staff member shall be present at any time there are clients at the facility. There shall be a staffing ratio of at least one (1) full-time equivalent direct service staff for each 2.5 clients served. All scheduled hours in the facility shall be considered part of this required full-time equivalent staffing ratio.

(c) To be certified as a Long-Term Residential Treatment Program, a program shall provide:

(1) Services as specified in subsection (j) of section 541 in order to provide a 24-hour therapeutic residential setting with a full range of social rehabilitation services, as defined in section 532 of these regulations, including day programming for individuals who require intensive support in order to avoid long-term hospitalization or institutionalization. The planned length of stay shall be in accordance with the client's assessed needs but under no circumstances may that length of stay be extended beyond eighteen (18) months.

(2) Scheduling of staff which provides for the maximum number of staff to be present during the times when clients are engaged in structured activities. At least one direct service staff shall be on the premises 24-hours a day, seven (7) days per week. Additional staff, including part-time or consulting services staff, shall be on duty during program hours to provide specialized services and structured evening services. When only one staff member is on the premises there shall be staff on call who can be contacted by telephone if an additional staff person is needed, and can be at the facility and on duty within 60 minutes after being contacted. There shall be a staffing ratio of at least one (1) full-time equivalent direct service staff member for each 2.8 clients served.

(d) “Direct service staff” shall mean employees whose duties include the treatment, training, care and/or supervision of the program's clients.

NOTE
Authority cited: Section 5458.1, Welfare and Institutions Code. Reference: Sections 5450, 5453, 5454 and 5458, Welfare and Institutions Code.

HISTORY
1. New section filed 1-3-91; operative 2-2-91 (Register 91, No. 7).

TITLE 9. Rehabilitative And Developmental Services
Division 1. Department of Mental Health
Chapter 3. Community Mental Health Services Under the Short-Doyle Act
Article 3.5. Standards for the Certification of Social Rehabilitation Programs
§532. Service Requirements.

§532. Service Requirements.

(a) Structured day and evening services shall be available seven (7) days a week. Services in all programs shall include, but not be limited to:

(1) Individual and group counseling;
(2) Crisis intervention;
(3) Planned activities;
(4) Counseling, with available members of the client's family, when indicated in the client's treatment/rehabilitation plan;
(5) The development of community support systems for clients to maximize their utilization of non-mental health community resources;
(6) Pre-vocational or vocational counseling;
(7) Client advocacy, including assisting clients to develop their own advocacy skills;
(8) An activity program that encourages socialization within the program and general community, and which links the client to resources which are available after leaving the program; and,
(9) Use of the residential environment to assist clients in the acquisition, testing, and/or refinement of community living and interpersonal skills.

(b) In addition to the services in subsection (a), Transitional Residential Treatment Programs shall provide services which emphasize the development of vocational skills, and linkages to services offering transitional employment or job placement.

(c) In addition to the services in subsection (a), Long-Term Residential Treatment Programs shall provide pre-vocational and vocational services. These services shall be designed to provide a continuum of vocational training and experience including volunteer activities, supported employment, transitional employment and job placement. When any of these vocational services are provided by outside agencies or programs, written agreements or documented treatment plans shall be developed consistent with the treatment goals and orientation of the program. Long-Term Residential Treatment Programs shall also include provisions for special education services and learning disability assessment and remediation.

NOTE
Authority cited: Section 5458.1, Welfare and Institutions Code. Reference: Sections 5450, 5453, 5454 and 5458, Welfare and Institutions Code.

HISTORY
1. New section filed 1-3-91; operative 2-2-91 (Register 91, No. 7).

TITLE 9. Rehabilitative And Developmental Services
Division 1. Department of Mental Health
Chapter 11. Medi-Cal Specialty Mental Health Services
Subchapter 2. Medi-Cal Psychiatric Inpatient Hospital Services
Article 2. Provision of Services
§1820.205. Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient Hospital Services.

§1820.205. Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient Hospital Services.

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

(1) One of the following diagnoses in the Diagnostic and Statistical Manual, Fourth Edition, published by the American Psychiatric Association:

(A) Pervasive Developmental Disorders
(B) Disruptive Behavior and Attention Deficit Disorders
(C) Feeding and Eating Disorders of Infancy or Early Childhood
(D) Tic Disorders
(E) Elimination Disorders
(F) Other Disorders of Infancy, Childhood, or Adolescence
(G) Cognitive Disorders (only Dementias with Delusions, or Depressed Mood)
(H) Substance Induced Disorders, only with Psychotic, Mood, or Anxiety Disorder
(I) Schizophrenia and Other Psychotic Disorders
(J) Mood Disorders
(K) Anxiety Disorders
(L) Somatoform Disorders
(M) Dissociative Disorders
(N) Eating Disorders
(O) Intermittent Explosive Disorder
(P) Pyromania
(Q) Adjustment Disorders
(R) Personality Disorders

(2) A beneficiary must have both (A) and (B):

(A) Cannot be safely treated at a lower level of care; and
(B) Requires psychiatric inpatient hospital services, as the result of a mental disorder, due to indications in either 1 or 2 below:

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

a. Represent a current danger to self or others, or significant property destruction.
b. Prevent the beneficiary from providing for, or utilizing, food, clothing or shelter.

c. Present a severe risk to the beneficiary's physical health.
d. Represent a recent, significant deterioration in ability to function.

2. Require admission for one of the following:

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

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

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

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

NOTE
Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

HISTORY
1. New section filed 10-31-97 as an emergency; operative 11-1-97 (Register 97, No. 44). A Certificate of Compliance must be transmitted to OAL by 3-2-98 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 3-2-98 as an emergency; operative 3-2-98 (Register 98, No. 10). A Certificate of Compliance must be transmitted to OAL by 6-30-98 or emergency language will be repealed by operation of law on the following day.
3. New section refiled 6-17-98 as an emergency; operative 6-30-98 (Register 98, No. 25). Pursuant to Chapter 324 (Statutes of 1998) Item 4440-103-0001(4), a Certificate of Compliance must be transmitted to OAL by 7-1-99 or emergency language will be repealed by operation of law on the following day.
4. Editorial correction of History 3 (Register 98, No. 39).
5. Editorial correction extending Certificate of Compliance date to 7-1-2001 pursuant to Chapter 50 (Statutes of 1999) Item 4440-103-0001(4) (Register 99, No. 33).
6. Editorial correction of History 5 (Register 2000, No. 42).

TITLE 22. Social Security
Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies
Chapter 9. Psychiatric Health Facilities
Article 3. Services
§77073. Interdisciplinary Treatment Plan.

§77073. Interdisciplinary Treatment Plan.

(a) A written interdisciplinary treatment plan shall be developed and implemented by the interdisciplinary treatment team for each patient as soon as possible after admission but no longer than 72 hours following the patient's admission, Saturdays, Sundays and holidays excepted.

(b) The interdisciplinary treatment plan shall include as a minimum:

(1) A statement of the patient's physical and mental condition, including all diagnoses.
(2) Specific goals of treatment with interventions and actions, and observable, measurable objectives.
(3) Methods to be utilized, the frequency for conducting each treatment method and the person(s) or discipline(s) responsible for each treatment method.

(c) The interdisciplinary treatment plan shall be reviewed and modified as frequently as the patient's condition warrants, but at least weekly.

NOTE
Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

HISTORY
1. New section filed 4-15-87, operative 5-15-87 (Register 87, No. 16).

TITLE 22. Social Security
Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies
Chapter 9. Psychiatric Health Facilities
Article 3. Services
§77061. Staffing.

§77061. Staffing.

(a) The facility shall have a clinical director who shall be a licensed mental health professional and qualified in accordance with Section 77093 of these regulations.

(b) The clinical director may also serve as the administrator.

(c) The clinical director shall designate a clinical psychologist or psychiatrist to review and approve interdisciplinary treatment plans.

(d) A physician shall be on-call at all times for the provision of physical health care and those services which can only be provided by a physician. The person in charge of patient care services on each shift shall be provided with the name(s) and means of locating and contacting the available physician. Patients requiring general acute physical health care shall be diverted from admission or transferred to a general acute care hospital. An individual patient may be admitted to a psychiatric health facility if the individual's physical health care could otherwise be managed on an outpatient basis.

(e) If the clinical director is not a physician, responsibility for those aspects of an individual treatment plan which may only be performed by a physician, shall be assumed by a physician.

(f) During the absence of any staff required in subsection (h)(1) below there shall be a substitute person with the required qualifications to provide the number of hours of services required.

(g) Community practitioners who are approved to admit and/or attend patients in the facility may be calculated as part of the staffing pattern only if they are retained by written contract to provide services for a specified number of hours to the patients at the facility.

(h) Each facility shall meet the following full-time equivalent staff to census ratio, in a 24 hour period:

View Graphic
(2) For facilities in excess of 100 beds, staffing shall be provided in the ratios as in (1) above.
(3) A registered nurse shall be employed 40 hours per week.

(4) There shall be a registered nurse, a licensed vocational nurse, or a psychiatric technician awake and on duty in the facility at all times.

(i) The required staffing ratio shall be calculated based upon the inpatient census and shall provide services only to psychiatric health facility patients.

(j) Regardless of the minimum staffing required in subsection (h)(1) above, the facility shall employ professional and other staff on all shifts in the number and with the qualifications to provide the necessary services for those patients admitted for care.

NOTE
Authority cited: Section 1275, Health and Safety Code. Reference: Sections 1250.2 and 1275.1, Health and Safety Code

HISTORY
1. New section filed 4-15-87, operative 5-15-87 (Register 87, No. 16).
2. Amendment of subsection (d) and amendment of Note filed 5-7-99; operative 6-6-99 (Register 99, No. 19).

TITLE 22. Social Security
Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies
Chapter 9. Psychiatric Health Facilities
Article 1. Definitions
§77004. Clinical Psychologist.

§77004. Clinical Psychologist.

Clinical psychologist means a psychologist licensed by this State and (1) who possesses an earned doctorate degree in psychology from an educational institution meeting the criteria for subdivision (c) of Section 2914 of the Business and Professions Code and (2) has not less than two years clinical experience in a multidisciplinary facility licensed or operated by this or another State or by the United States to provide health care, or, is listed in the latest edition of the National Register of Health Service Providers in Psychology, as adopted by the Council for the National Register of Health Service Providers in Psychology.

NOTE
Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

HISTORY
1. New section filed 4-15-87, operative 5-15-87 (Register 87, No. 16).

TITLE 22. Social Security
Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies
Chapter 9. Psychiatric Health Facilities
Article 1. Definitions
§77011.2. Licensed Clinical Social Worker.

§77011.2. Licensed Clinical Social Worker.

Licensed clinical social worker means a person who possesses a master's degree from an accredited school of social work and two years of post master's experience in a mental health setting; and shall have obtained a license as a clinical social worker by the California Board of Behavioral Science Examiners.

NOTE
Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

HISTORY
1. New section filed 4-15-87, operative 5-15-87 (Register 87, No. 16).

TITLE 22. Social Security
Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies
Chapter 9. Psychiatric Health Facilities
Article 1. Definitions
§77012. Licensed Mental Health Professional.

§77012. Licensed Mental Health Professional.

Licensed mental health professional means any of the following:

(a) A licensed psychologist who qualifies as a clinical psychologist as defined in these regulations.

(b) A psychiatrist as defined in these regulations.

(c) A licensed clinical social worker, as defined in these regulations.

(d) A licensed marriage, family and child counselor as defined in these regulations.

NOTE
Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.)

HISTORY
1. New section filed 4-15-87, operative 5-15-87 (Register 87, No. 16).

TITLE 22. Social Security
Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies
Chapter 9. Psychiatric Health Facilities
Article 1. Definitions
§77012.1. Licensed Psychiatric Technician.

§77012.1. Licensed Psychiatric Technician.

Licensed psychiatric technician means a person licensed as such by the California Board of Vocational Nurse and Psychiatric Technician Examiners.

NOTE
Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

HISTORY
1. New section filed 4-15-87, operative 5-15-87 (Register 87, No. 16).

TITLE 22. Social Security
Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies
Chapter 9. Psychiatric Health Facilities
Article 1. Definitions
§77012.2. Licensed Vocational Nurse.

§77012.2. Licensed Vocational Nurse.

Licensed vocational nurse means a person licensed as such by the California Board of Vocational Nurse and Psychiatric Technician Examiners.

NOTE
Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

HISTORY
1. New section filed 4-15-87, operative 5-15-87 (Register 87, No. 16).

TITLE 22. Social Security
Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies
Chapter 9. Psychiatric Health Facilities
Article 1. Definitions
§77017. Mental Health Worker.

§77017. Mental Health Worker.

Mental health worker means a person who does not qualify as a licensed health professional but who through experience, inservice training or formal education, is qualified to participate in the care of the psychiatric patient.

NOTE
Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1275.1 and 1276.1, Health and Safety Code.

HISTORY
1. New section filed 4-15-87, operative 5-15-87 (Register 87, No. 16).

TITLE 22. Social Security
Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies
Chapter 9. Psychiatric Health Facilities
Article 1. Definitions
§77023. Psychiatrist.

§77023. Psychiatrist.

Psychiatrist means a person who is licensed as a physician and surgeon in California and shows evidence of having completed three years graduate training in psychiatry in a program approved by the American Medical Association or the American Osteopathic Association.

NOTE
Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

HISTORY
1. New section filed 4-15-87, operative 5-15-87 (Register 87, No. 16).

TITLE 22. Social Security
Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies
Chapter 9. Psychiatric Health Facilities
Article 3. Services
§77059. Basic Services.

§77059. Basic Services.
The facility may provide services to patients either directly or by written agreement with outside resources as specified in Section 77109.

NOTE
Authority cited: Section 208(a) and 1275, Health and Safety Code. Reference: Sections 1250.2 and 1275.1, Health and Safety Code.

HISTORY
1. New section filed 4-15-87, operative 5-15-87 (Register 87, No. 16).

TITLE 22. Social Security
Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies
Chapter 9. Psychiatric Health Facilities
Article 3. Services
§77063. Psychiatric, Psychological and Counseling Services.

§77063. Psychiatric, Psychological and Counseling Services.

(a) Psychiatric services shall be provided by licensed physicians with training and/or experience in psychiatry.

(b) Psychological services shall be provided by clinical psychologists in accordance with Business and Professions Code, Section 2903 and Health and Safety Code, Section 1316.5.

(c) Counseling services shall be provided by licensed clinical social workers in accordance with Business and Professions Code, Sections 4996 and 4996.9, or licensed marriage, family and child counselors in accordance with Business and Professions Code, Sections 4980 and 4980.02.

NOTE
Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1250.2 and 1275.1, Health and Safety Code.

HISTORY
1. New section filed 4-15-87, operative 5-15-87 (Register 87, No. 16).

TITLE 22. Social Security
Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies
Chapter 9. Psychiatric Health Facilities
Article 3. Services
§77065. Psychiatric Nursing Services.

§77065. Psychiatric Nursing Services.

(a) Psychiatric nursing services shall be designed to meet the objectives of each patient's interdisciplinary treatment plan.

(b) Policies and procedures for the administration of medications shall be implemented by the psychiatric nursing service.

(c) Nursing services shall include the development of a nursing care plan based upon an initial written and continuing assessment with input from health professionals involved in the care of the patient. Initial assessments shall commence at the time of admission of the patient and be completed within 72 hours after admission. Nursing care plans shall either be included as a part of the interdisciplinary treatment plan or occupy a unique section of the patient record.

(d) Written nursing services policies and procedures shall be developed which include:

(1) A current nursing procedure manual appropriate to the patients served by the facility.
(2) Provision for the inventory and identification of patients' personal possessions, equipment and valuables.
(3) Screening of all patients for tuberculosis upon admission. A tuberculosis screening procedure may not be required if there is satisfactory written evidence available that a tuberculosis screening procedure has been completed within 90 days of the date of admission to the facility. Subsequent tuberculosis screening procedures shall be determined by a physician.
(4) Notification of practitioner regarding sudden or marked adverse change in a patient's condition.
(5) Conditions under which restraints are used, the application of restraints, and the mechanism used for monitoring and controlling their use.
(6) A planned and systematic process for the monitoring and evaluation of the quality and appropriateness of patient care and for resolving identified problems.

(e) Psychiatric nursing policies and procedures shall either be integrated into a separate section of a general manual or contained in a policy and procedure manual dedicated to nursing policies and procedures.

(f) There shall be a written staffing pattern which shall show:

(1) Total numbers of staff including full-time and full-time equivalents.
(2) The available nursing care hours for each nursing unit.
(3) The categories of staff available for patient care.

(g) The psychiatric nursing service shall be under the direction of a registered nurse who shall meet at least the following qualification:

(1) Master's degree in psychiatric nursing or related field with experience in administration; or
(2) Baccalaureate degree in nursing or related field with experience in psychiatric nursing and two years of experience in nursing administration; or
(3) Four years of experience in nursing administration or supervision and with experience in psychiatric nursing.

(h) Psychiatric health facility policies and procedures shall specify how a registered nurse will exercise authority and carry out the responsibility of supervising nursing activities such as, but not limited to:

(1) Dispensing, and recording of medication(s).
(2) Documenting patients' nursing care needs in the interdisciplinary treatment plan.
(3) Implementing nursing procedures.
(4) Providing inservice education related to nursing activities.

NOTE
Authority cited: Section 1275, Health and Safety Code. Reference: Sections 1250.2 and 1275.1, Health and Safety Code.

HISTORY
1. New section filed 4-15-87, operative 5-15-87 (Register 87, No. 16).
2. Amendment of subsection (c), new subsection (e), subsection relettering, new subsections (h)-(h)(4) and amendment of Note filed 5-7-99; operative 6-6-99 (Register 99, No. 19).

TITLE 22. Social Security
Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies
Chapter 9. Psychiatric Health Facilities
Article 3. Services
§77067. Social Services.

§77067. Social Services.

(a) Social services shall be designed to meet the objectives of each patient's interdisciplinary treatment plan in accordance with established policies and procedures.

(b) Social services shall be organized, directed and supervised by a licensed clinical social worker.

NOTE
Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1250.2 and 1275.1, Health and Safety Code.

HISTORY
1. New section filed 4-15-87, operative 5-15-87 (Register 87, No. 16).

TITLE 22. Social Security
Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies
Chapter 9. Psychiatric Health Facilities
Article 3. Services
§77069. Rehabilitation Services.

§77069. Rehabilitation Services.

(a) Rehabilitation services mean those activities provided by occupational therapists, physical therapists or recreation therapists under the general direction of the clinical director to restore, establish and maintain optimum levels of social, vocational and physical functioning and to minimize residual disabilities of patients. Rehabilitation services provided in a psychiatric health facility are to be designed to meet the needs of acute psychiatric inpatients.

(b) In accordance with established policies and procedures, the scope of these activities shall include at least the following:

(1) Social activities which involve group participation.
(2) Recreational activities, both indoor and outdoor.
(3) Opportunity to participate in activities outside of the facility if appropriate.
(4) Exercises.

(c) A physician shall prescribe in the health record the level of physical activity in which a patient may engage.

NOTE
Authority cited: Section 1275, Health and Safety Code. Reference: Sections 1250.2 and 1275.1, Health and Safety Code.

HISTORY
1. New section filed 4-15-87, operative 5-15-87 (Register 87, No. 16).
2. Amendment of subsection (a) and amendment of Note filed 5-7-99; operative 6-6-99 (Register 99, No. 19).

TITLE 22. Social Security
Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies
Chapter 9. Psychiatric Health Facilities
Article 3. Services
§77079.1. Pharmaceutical Services--General.

§77079.1. Pharmaceutical Services--General.

(a) Arrangements shall be made with pharmacists licensed by the California Board of Pharmacy to assure that pharmaceutical services are available to provide patients with prescribed drugs and biologicals.

(b) Dispensing, labeling, storage, disposal and administration of drugs and biologicals shall be in conformance with state and federal laws.

(c) If a pharmacy is located on the premises, the pharmacy shall be approved by the Department. The pharmacy shall not serve the general public unless a separate public entrance or a separate public serving window is utilized. Pharmacies located on the licensed premises of the facility shall be opened for inspection upon the request of an authorized Department representative.

(d) The facility shall not accept money, goods or services free or below cost from any pharmacist or pharmacy as compensation or inducement for referral of business to any pharmacy.

NOTE
Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code; Sections 650 and 651, Business and Professions Code.

HISTORY
1. New section filed 4-15-87, operative 5-15-87 (Register 87, No. 16).

TITLE 22. Social Security
Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies
Chapter 9. Psychiatric Health Facilities
Article 3. Services
§77079.12. Pharmaceutical Services--Staff.

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(a) Facilities shall retain a consulting pharmacist who devotes a sufficient number of hours during a regularly scheduled visit, for the purpose of coordinating, supervising and reviewing the pharmaceutical service at least quarterly. The report shall include a log or record of time spent in the facility. There shall be a written agreement between the pharmacist and the facility which includes the duties and responsibilities of both.

(b) A pharmacist shall review the drug regimen of each patient at least monthly and prepare appropriate reports. The review of the drug regimen of each patient shall include all drugs currently ordered, information concerning the patient's condition relating to drug therapy, medication administration records, and where appropriate, physician's progress notes, nurse's notes, and laboratory test results. The pharmacist shall be responsible for reporting, in writing, irregularities in the dispensing and administration of drugs and other matters relating to the review of the drug regimen to the clinical director and the director of nursing service.

NOTE
Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code; Sections 650 and 651, Business and Professions Code.

HISTORY
1. New section filed 4-15-87; operative 5-15-87 (Register 87, No. 16).