

The California Institute for Mental Health
**Early and Periodic Screening
Diagnosis and Treatment (EPSDT)**
Chart Documentation Manual



By
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Publication Design by
Jennifer Doyle

*A California Institute for
Mental Health Publication*



The California Institute for Mental Health

EARLY AND PERIODIC
SCREENING DIAGNOSIS AND
TREATMENT (EPSDT)

CHART DOCUMENTATION MANUAL

By

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September 2007

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Use of the EPSDT Chart Documentation Manual

This EPSDT Chart Documentation Manual is presented to you by the California Institute for Mental Health (CiMH). This manual is to be used as a reference guide and is not a definitive single source of information regarding chart documentation requirements.

In all cases, the reader should defer to California Code of Regulations, Title 9, State and Federal regulations and Mental Health Plan (MHP) contractual requirements and applicable MHP policies and procedures. In addition, MHP's may require additional standards and other requirements that are not covered in this manual. "The MHP has the authority to administrate and authorize services according to program and organizational need." (Welfare & Institution Code 14680-14684).

Contact your MHP for information and guidance regarding use of this manual.

Acknowledgement

This EPSDT Chart Documentation reference manual is the culminated effort of many contributors and stakeholders: The California State Department of Mental Health, the California Mental Health Directors Association, the California Alliance of Child and Family Services, and the California Council of Community Mental Health Agencies. Particular thanks and recognition should be extended to the following counties and individuals for their guidance, encouragement, assistance and finally for their significant contributions to the development of this manual:

- Los Angeles County Department of Mental Health
- Orange County Behavioral Health Services
- Sacramento County Division of Mental Health
- San Francisco County Community Behavioral Health Services
- Adrienne Shilton, MPPA - Senior Policy Analyst, California Council of Community Mental Health Agencies
- Alex Agnieszka Medina, LCSW - Director of Quality Improvement, Child and Family Guidance Center
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- Don Kingdon, PhD - Deputy Director, Small Counties Liaison, California Mental Health Directors Association
- George Holbrook, MFT - Corporate Director of Quality Improvement and Compliance, Pacific Clinics
- Julie Agojo, RN - Staff Mental Health Specialist, California Department of Mental Health
- Katherine West - Executive Director, Seneca Center
- Kim Suderman, LCSW - Deputy Director, San Joaquin County Behavioral Health
- Maggie Roberts, Esq - Associate Managing Attorney, Protection and Advocacy, Inc.
- Nicette Short, MPA - Senior Policy Advocate, California Alliance of Child and Family Services
- Norma A. Fritsche, RN, CNS, MPA - Mental Health Clinical Program Head, Standards and Quality Assurance, Los Angeles County Department of Mental Health
- Pam Hawkins, Associate II - Child and Families Team, California Institute for Mental Health
- Rita McCabe, LCSW - Chief of Medi-Cal Mental Health Policy Branch, California Department of Mental Health
- Suzanne Tavano, BSN, PhD - Deputy Director of Mental Health, Contra Costa County Mental Health
- Twylla Abrahamson, PhD - Program Manager, Placer County Children's System of Care
- Uma Zykofsky, LCSW - Program Manager, Quality Management, Sacramento County Division of Mental Health

This acknowledgement does not indicate an endorsement of the EPSDT Chart Documentation Manual.

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Introduction

1.1 Background (Brief Historical Perspective) and Manual Overview

The Medi-Cal Program began in 1965 when Congress passed two amendments to the Social Security Act that provided health benefits to individuals eligible for federal welfare grants. This legislation established Medicare for persons 65 years of age and over, and Medicaid for persons who were in the aged, blind, disabled, and family aid programs.

In 1966, California passed legislation to implement the Medicaid program by establishing the California Medical Assistance Program in the Office of Health Care Services. Since that time, the program has become known as the Medi-Cal program, and now includes many additional specialized programs. The California Department of Health Services (DHS) is the single state agency that administers the program.

The Medi-Cal program originally consisted of physical health care benefits with mental health treatment making up only a small part of the program. Mental health services were limited to treatment provided by physicians (psychiatrists), psychologists, hospitals, and nursing facilities and were reimbursed through the Fee-For-Service Medi-Cal system (FFS/MC).

Short-Doyle Act

In 1957, California passed the Short-Doyle Act (an act authored and introduced simultaneously to the Senate and Assembly by Senator Short and Assemblyman Doyle following the submission of recommendations resulting from a series of committee meetings by physicians, psychiatrists and representatives of lay organizations interested in the unmet needs in mental health field with the then “California Department of Mental Hygiene”).¹ This act provided matching state funds to counties and cities for delivery of mental health services to their residents. The match-

ing ratio evolved from 50% state funds/50% county funds to 75% state funds/25% county funds, then eventually to 90% state funds/10% county funds in 1969 when it became mandatory for counties with populations over 100,000 to provide mental health services. In FY 1973-74, it became mandatory for all counties to have a mental health program.

There was no federal funding of the Short-Doyle program until the early 1970’s, when it was recognized that local county mental health programs were treating many Medi-Cal recipients. Short-Doyle/Medi-Cal (SD/MC) started as a pilot project in 1971, and counties were able to obtain federal matching funds to provide certain mental health services to Medi-Cal eligible individuals. The SD/MC program offered a broader range of mental health services than those provided by the original Medi-Cal program. The SD/MC program now includes acute inpatient care, adult residential treatment, crisis residential treatment, crisis stabilization, intensive day treatment, day rehabilitation, linkage and brokerage, mental health services, medication support, and crisis intervention.

Realignment

In January, 1991 then Governor Wilson proposed in his FY 1991-92 State Budget to “realign” the funding responsibility for Assembly Bill 8 (AB 8 Greene)/County Health Services and Community Mental Health programs by shifting a greater share of the cost of such programs to the counties. By the time the “Budget Revise” was issued in May, the state’s budget deficit had grown worse and the concept of realignment was substantially expanded in order to further reduce state costs.²

“Realignment” is funded through a half-cent increase in the state sales tax and through a dedi-

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cated portion of the Vehicle License Fees (VLF). While the sales tax revenue was directed to all three Realignment accounts (Health, Mental Health, and Social Services), the VLF revenue was directed largely to the Health account with a smaller portion of the VLF also supporting Mental Health and Social Services. Approximately 85% of the Mental Health Account is comprised of sales tax revenue, with the remainder from VLF revenue. As with the Health Account, once all caseload growth costs have been funded in the Social Services Account, the Mental Health Account receives a portion of any remaining sales tax and VLF growth.

By the end of FY 1991-92 budget negotiations, nineteen state/county health, mental health, and social services programs were realigned. Under Realignment, the county share of cost of most of the realigned programs was increased and funded by new revenue sources. With the decrease of appropriated state funding, counties were granted increased flexibility in managing some of the realigned programs, most notably in mental health (Community Based, Institutes for Mental Disease, and State Hospitals). They also received some assurance of a dedicated revenue source that would grow over time.

The allocation of this funding source was based on the county's (and a few cities: Berkeley, Long Beach, Pasadena and the Tri-City area of Claremont, LaVerne, and Pomona) level of funding just prior to Realignment and were rooted in historical formulas and spending patterns; in other words, the realignment formulas emphasized maintaining the county funding levels in existence at the time of its enactment.

With the passage of the realignment legislation, the adult and child target population definitions

were put in statute (see Welfare and Institutions Code Section 5600.3), to prioritize service delivery.^{3,4}

In recent years, the Legislature has reduced the VLF tax rate. As of FY 2001-02, the effective rate was 67.5% lower than it was in 1998. The state's "General Fund", through a continuous appropriation to local governments outside of the annual budget process replaces the dollars that were previously paid by vehicle owners. In other words, realignment continues to receive the same amount of dollars from VLF sources as under prior law.⁵

Mental Health Programs (Two Systems, Two Options)

The two separate Medi-Cal mental health systems, FFS/MC (the original Medi-Cal mental health system) and SD/MC, continued as separate programs until Medi-Cal mental health consolidation began in January 1995. At that time, DHS transferred responsibility for acute inpatient care to DMH and county mental health programs. Outpatient specialty mental health services were consolidated through a phased-in implementation by counties during FY 1997-98.

Additionally, in the early 90's the mental health service delivery system shifted from a rigid model of "clinic option" that was in-office, practitioner-focused and driven, to a "Rehabilitative Services Option" ("Rehab Option") that was a more flexible benefit that could provide services in the community by a wider range of individuals, including qualified community paraprofessional workers and peer specialists when rendered under the supervision of a "licensed practitioner of the healing arts" (LPHA).

Most important, rehabilitation services may ex-

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tend beyond the clinical treatment of a person's mental illness to include helping the person to acquire skills that are essential for everyday functioning (e.g., symptom management, daily living skills, socialization skills, etc.).⁶

Managed Care

As the state began to move towards managed care in health services delivery to the Medi-Cal population, one of the driving forces was a system which would integrate and coordinate care. This naturally led to the plan to consolidate the two Medi-Cal funding streams for mental health services. Implementing managed care was also designed to provide a cost containment strategy that would allow a prudent purchaser of services to obtain maximum benefit for its expenditures and would allow for increased access to specialty mental health services within the same level of funding. Consolidating the two mental health funding streams would help achieve this by improving care coordination and reducing administrative costs. In addition, consolidating services would help assure consistent statewide access to persons receiving specialty mental health services. Access to services was a critical concern for the former Health Care Financing Administration (HCFA, now called Center for Medicare and Medicaid Services - CMS) in evaluating the state's plans for delivery of managed health care for the Medi-Cal population.⁷

The Medi-Cal Specialty Mental Health Services Consolidation program began in January 1995 with county mental health departments taking on responsibility for authorization and payment of all Medi-Cal covered psychiatric inpatient hospital services for beneficiaries in the county. Previously, county mental health departments had managed psychiatric inpatient hospital services only at county hospitals or hospitals under

contract to the county. All other psychiatric inpatient hospital services were managed by DHS through the regular Medi-Cal program. Between November 1997 and July 1998, these county mental health departments, now called mental health plans (MHPs), also assumed responsibility for inpatient hospitals and outpatient specialty mental health professional services in addition to their previous responsibility to provide rehabilitative mental health and targeted case management services.

Currently, the MHPs select and credential their provider network, negotiate rates, authorize services, and provide payment for services rendered by specialty mental health providers in accordance with statewide criteria. Medi-Cal beneficiaries must receive Medi-Cal reimbursed specialty mental health services through the MHPs.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

In addition to the changes in service delivery through a managed care model, another new program, "Early and Periodic Screening, Diagnosis, and Treatment program" (EPSDT), that was introduced by the federal government in 1989 was making its way into state programs across the United States. This new program also broadened and enhanced mental health delivery services for children.

EPSDT is a comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) legislation and includes periodic screening, vision, dental, and hearing services. In addition, Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at Section 1905(a) of the Act

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be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population. The EPSDT program consists of two mutually supportive, operational components:

1. Assuring the availability and accessibility of required health care resources; and,
2. Helping Medicaid recipients and their parents or guardians effectively use these resources.

These components enable Medicaid agencies to manage a comprehensive child health program of prevention and treatment, to seek out eligible children and inform them of the benefits of prevention and the health services and assistance available and to help them and their families use health resources, including their own talents and knowledge, effectively and efficiently. It also enables them to assess the child's health needs through initial and periodic examinations and evaluations, and also to assure that the health problems found are diagnosed and treated early, before they become more complex and their treatment more costly.⁸

California Code of Regulations, Title 9, Chapter 11, defines EPSDT as mental health related diagnostic services and treatment, other than physical health care, available under the Medi-Cal program only to persons under 21 years of age pursuant to Title 42, Section 1396d(r), United States Code, that have been determined by the State Department of Health Services to meet the criteria of Title 22, Section 51340(e)(3) or (f); and that are not otherwise covered by this Chapter as specialty mental health services.⁹

Furthermore, EPSDT specialty mental health services are those services defined in the California Code of Regulations (CCR) Title 22, Section 51184, that

are provided *to correct or ameliorate* the diagnoses listed in Section 1830.205, and that are not otherwise covered... (Authority provided by Section 14680 of the Welfare and Institution Code).¹⁰

The Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT) was first implemented by the California State Department of Mental Health (DMH) in Fiscal Year 1995-96.

EPSDT differs from the CCR, Title 9, Chapter 11, Section 1830.205(a)(1)(A-R) for Medical Necessity by permitting a broader definition and inclusion of diagnosed mental illness that is not limited to targeted population criteria established in the Welfare and Institution Code §5600.3 for Seriously Emotionally Disturbed children and adolescents.

Since EPSDT's introduction, access to Specialty Mental Health Services have dramatically increased over time providing more access and availability of mental health resources for California beneficiaries between the ages of 0-21.¹¹

The Department of Health Services (DHS) developed an interagency agreement with DMH through which county mental health plans (MHPs) were reimbursed the entire non-federal share of cost for all EPSDT-eligible services in excess of the expenditures during Fiscal Year 1994-95. EPSDT services continued to significantly expand. In Fiscal Year 2002-03's State Budget, a 10% share of cost was required for all EPSDT services above a baseline expenditure threshold level with county Realignment funding or from other funding sources (including County General Funds).¹² Additionally, increased oversight of EPSDT services by both DMH and MHPs provided heightened quality assurance and program direction as EPSDT service delivery evolved.

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In July 1999, following the preliminary injunction in the *Emily Q. vs. Belshé* lawsuit, Mental Health Plans (MHPs) also became responsible for the provision of the EPSDT supplemental specialty mental health service, Therapeutic Behavioral Services (TBS). TBS consists of intensive one-to-one services for children/youth who meet TBS criteria and who are experiencing a stressful transition or life crisis and need additional short-term support to prevent placement in a group home of Rate Classification Level 12 or above, a locked facility for the treatment of mental health needs (including acute care), or to enable a transition to a lower level of residential care. These services are not stand alone services and are intended to supplement other EPSDT specialty mental health services.¹³ Currently, the only listed EPSDT *supplemental* specialty mental health service is TBS.¹⁴

Since January 2005, DMH has been responsible for conducting chart reviews of EPSDT services provided by selected legal entities, as defined in Title 9, Section 1840.100 of the California Code of Regulations. These reviews are performed by a DMH contractor.

The DMH contractor reviews a sample of DMH-approved claims submitted by the selected legal entities during the review period utilizing a published document entitled *EPSDT Reasons for Recoupment*.

As the result of language included in Assembly Bill 1807 and budget trailer bill FY 2006-07, the State Department of Mental Health revised its method for auditing entities, that provide specialty mental health services under the EPSDT Program, and its method for extrapolating data obtained from those audits, pursuant to this section. Commencing July 1, 2006, and continuing

thereafter, the following provisions apply:

- a. DMH shall select statistically valid stratified samples by service function for each entity to be audited;
- b. DMH shall not extrapolate the results of any audit to the full audited service function unless the error rate determined by the audit is five percent or greater. If the error rate is less than five percent the department shall disallow only the specific claims found to be in error;
- c. DMH, in consultation with stakeholders, shall select an independent statistician to review the sampling methodology and extrapolation methodology used by the department. No later than October 1, 2006, the statistician shall prepare a public report on the statistical validity of those methodologies. If the statistician determines either methodology to be invalid, the department shall adopt a new methodology, which shall be used by the department only after its validity is verified by the statistician.¹⁵

In addition to the statistical sampling review, additional funding was appropriated to be used to contract, develop and provide training for counties and provider organizations, as well as to develop a chart documentation manual, on billing procedures and related processes associated with operating an effective and qualitative EPSDT program.

To meet these requirements, DMH has engaged the California Institute for Mental Health (CiMH) to provide the Department with three EPSDT documentation training products during Fiscal Year 2006-2007. CiMH developed and presented a short-term training program de-

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1.1 Background (Brief Historical Perspective) and Manual Overview

signed to address and reduce the most common errors, as well as improve the quality of clinical documentation. Second, CiMH was authorized to develop a documentation training manual to assist legal entities in improving the quality of EPSDT documentation, thus reducing disallowance levels. Finally, CiMH was further authorized to develop and present a training program based on this manual. It is expected that this EPSDT Chart Documentation Manual and training will be updated periodically to reflect changes in stat-

ute, regulation, policy, or in contract.

The intent of this manual is to provide a point of reference and direction in the documentation of EPSDT services and other EPSDT supplemental specialty mental health services. It is intended that this documentation manual will provide guidance to EPSDT Providers to aid in the documentation of these services in a quality driven, culturally competent, comprehensive and standardized framework.

Introduction

1.2 Freedom of Choice Waiver

Currently, specialty mental health services operates under a “Freedom of Choice” waiver, under Section 1915(b) of the federal Social Security Act. This waiver, which is reviewed and approved by the Center for Medicare and Medicaid Services (CMS), allows California to limit a Medi-Cal beneficiary’s choice of providers for mental health services as long as access and quality of services are ensured. Currently, Counties contract with DMH as the County’s Mental Health Plan (MHP) to provide medically-necessary specialty mental health services to the beneficiaries of the county. This waiver is subject to review by the Centers for Medicare & Medicaid Services (CMS) and must be renewed every two years.¹⁶

The decision to provide specialty mental services in California through a single managed care plan in each county (i.e., the MHP) logically followed the decision to carve out specialty mental health services and to consolidate the two mental health delivery systems. This decision necessitated a “freedom of choice” waiver from CMS. This

waiver allowed California to have a single plan model whereby beneficiaries in need of specialty mental health services have one plan available in each county as opposed to the more traditional managed care model of a choice of at least two plans in each locality from which beneficiaries may choose. Provisions to assure that access to specialty mental health care was not reduced as a result of the implementation of the single plan model and that beneficiary protection mechanisms were satisfactory in the context of a single plan model were a key part of the waiver.¹⁷

Mental Health Plans, under contract with DMH, are required to ensure the accessibility and quality of care provided. DMH Medi-Cal Oversight conducts a review of the MHP using the Review Protocol for Consolidated Specialty Mental Health Services and Other Funded Services once every three years and issues reports to the MHP detailing findings, recommendations, and corrective action(s), as appropriate.¹⁸ Currently, DMH arranges for an annual external quality review by an External Quality Review Organi-

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1.2 Freedom of Choice Waiver

zation (EQRO) as required by Title 42, CFR, Section 438.204(d) and regular program reviews conducted by on-site EPSDT chart reviews.¹⁹

NOTE: For the purposes of this reference manual the term “child” or “youth” may be used interchangeably with the term “beneficiary”.

Introduction

1.3 Early and Periodic Screening Diagnosis Documentation Manual Use

The **EPSDT Chart Documentation Manual** is organized into seven chapters that cover planned (services required on the client plan) and unplanned (services not required on the client plan) specialty mental health services, case management, and targeted case management services. Additionally, the manual addresses the topic of reimbursable and non-reimbursable activities, general documentation standards, and staff qualifications. Appendices include the ICD-9 “Included Diagnoses” list for EPSDT, a list of Reasons for Recoupment (current at time of publication), crosswalks for “lock-out” and “staffing,” a quick-reference regulatory and state code glossary of terms used in this manual, a list of contacts and on-line resources (current at time of publication), and a sequential accounting of “source citations.”

The use of this Manual is for quick reference and assistance in the delivery of EPSDT services. It is intended to be a guide and is neither comprehensive nor definitive. This manual is based on

multiple resources including, but not limited to, regulations, laws, codes, DMH Letters and Notices, MHP Contract, and suggested best practice.

It should be noted that the Mental Health Plan has the authority to administrate and authorize services according to program and organizational need.²⁰

It is highly recommended and encouraged that one contact the local MHP Quality Assurance or Management unit whenever there is a need for clarification and application of the information contained herein.

This manual should be considered a “living” and “dynamic” document and will be periodically reviewed and updated. This manual will be posted on the CiMH internet website for ease of access and distribution. Please periodically check the CiMH website for any posted changes or amendments regarding this document. (www.CiMH.org)

Planned Services

2.1 Mental Health Services

Description

EPSDT “Mental Health Services” means individual or group therapies and interventions that are designed to provide reduction of mental disability and restoration, 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, cri-

Planned Services

2.1 Mental Health Services

sis 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.²¹

Since Mental Health Services are provided as a component of crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, and day treatment intensive, Mental Health Services cannot be claimed separately during the hours these programs operate, however, Mental Health Plans (MHPs) must require providers to request initial MHP payment authorization for counseling, psychotherapy or other similar therapeutic interventions, excluding services to treat emergency and urgent conditions and Therapeutic Behavioral Services (TBS), that will be provided on the same day that Day Treatment Intensive (DTI) or Day Rehabilitation (DR) service program is being provided to the beneficiary.²²

Mental Health Service Activities

The following service activities are reimbursable as Mental Health Services when rendered to Medi-Cal beneficiaries under age 21. Not all of these activities need to be provided during the same intervention for a service activity to be reimbursable. The MHP retains the authority to dictate and set the parameters regarding these activities per program and staffing needs.

Individual therapy is already a component of Day Treatment Intensive. Additional individual therapy can be provided on the day that Day Treatment Intensive is being provided but not during Day Treatment Intensive program hours. Documentation must support that this service is provided outside the hours of the DTI program.

1. Assessment

Assessment is defined as a service activity designed to evaluate the current status of a child's mental, emotional, or behavioral health. Assessment includes, but is not limited to, one or more of the following: mental status determination, analysis of the child's clinical history; analysis of relevant cultural issues and history; diagnosis; and the use of testing procedures.²³ (See Chapter 6.3 regarding required Assessment content)

Note: In regards to psychological testing, "Psychologist Services" means services provided by licensed psychologists, within their scope of practice, to diagnose or treat a mental illness or condition. Psychologist services may only be provided under the direction of a licensed clinical psychologist (Example: Testing provided by Psychological Assistants, Graduate Students, Registered Psychologist under the supervision of a licensed clinical psychologist), within the scope of practice and training of the practitioner, who are individual or group providers.²⁴

2. Plan Development

Plan Development is defined as a service activity that consists of development of client plans, approval of client plans, and/or monitoring and recording of a child's progress.²⁵ (See Chapter 6.4 regarding required Client Plan content)

3. Therapy

Therapy is defined as a service activity that is a therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments. Therapy may be delivered to a child or a group of children and may include family therapy at which the child is present.²⁶

4. Rehabilitation

Rehabilitation is defined as a service activity that includes, but is not limited to, assist-

Planned Services

2.1 Mental Health Services

ance in improving, maintaining, or restoring a child's or group of children's functional skills, daily living skills, social and leisure skills, and grooming and personal hygiene skills; obtaining support resources; and/or obtaining medication education.²⁷

It is important to distinguish "Rehabilitation" versus "personal care activities." Personal care activities are not reimbursable.²⁸

Rehabilitation and Personal Care Services both assist clients to live independently. **Rehabilitation**, however, does this by activities that are designed to enable the client to overcome the limitations due to the mental disorder and teach the client to perform these activities for themselves. **Personal Care Services** do this by performing activities for the clients that the clients are unable to do for themselves.²⁹

Rehabilitation might include teaching a client to shop, prepare and eat meals, as well as reviewing the effectiveness of the instruction at periodic intervals. Personal care services might include food shopping, meal preparation and feeding the client.³⁰ Rehabilitation might include planning social activities with the client consistent with the client's socialization goals and encouraging/monitoring the client's participation in these activities. There is no comparable Personal Care Services, since no one can perform social activities for another.³¹

Example: Watching a child or adolescent whose diagnosis is Conduct Disorder (childhood-onset type) play basketball during recess or a break is not reimbursable. Individualizing the activity for this same child who has a history of repetitive and persistent pattern of breaking rules, bullying, threatening, and fighting with his peers by modeling and coaching the child to be a team player, and praising him for positive interactive behavior with peers during a basketball game is reimbursable as Rehabilitation if this is tied to the previously assessed maladaptive behaviors and part of the Client Plan.

It should be noted that Rehabilitative activities are designed to enable the client to overcome the limitations due to the mental disorder and teach the client to function in age appropriate manner without the need for redirection or intervention.³²

5. Collateral

Collateral is defined as a service activity to a *Significant Support Person* in a child's life for the purpose of meeting the needs of the child in terms of achieving the goals of the *youth's* client plan. Collateral may include, but is not limited to, consultation and training of the significant support person(s) to assist in better utilization of mental health services by the child, consultation and training of the significant support person(s) to assist in better understanding of the *youth's* serious emotional disturbance; and family counseling with the significant support person(s) in achieving the goals of the *youth's* client plan.³³ The youth may or may not be present for this service activity.³⁴



Planned Services

2.1 Mental Health Services

Note: Contact with a Significant Support Person must be documented in the chart. If contact is made by letter, best practice recommends that a copy of the correspondence be placed in the chart as substantiation of compliance. The practice of due diligence in assuring confidentiality should be made whenever Protected Health Information (PHI) is sent to a Significant Support Person.

If contact is made by phone, it is recommended that charting include what transpired in the communication with the Significant Support Person and what actions are being taken in supporting the client's reintegration into the community.

A "Significant Support Person" is defined as a person who, in the opinion of the child/youth, or the person providing services, who has or could have a significant role in the successful outcome of treatment, including but not limited to the parents or legal guardian or relatives of the child/youth or a person living in the same household as the child/youth, a legal representative of a child/youth who is not a minor, a person living in the same household as the child/youth, and relatives of the child/youth.³⁵

Note: Contacts with Significant Support Persons in the child/youth's life are directed exclusively to the mental health needs of the client/youth.³⁶

Caution must be taken to ensure applicable authorizations are in place to preserve confidentiality and protected health information.

Contact and Site Requirements (Mental Health Services)

Mental Health Services may be either face-to-face or by telephone with the child or Significant Support Person(s) and may be provided anywhere in the community.³⁷

As per CCR, Title 9, 1840.316(4), plan development for Mental Health Services and Medication Support Services may be claimed regardless of whether there is a face-to-face or phone contact with the child/youth.

Example: Staff member accompanies client on an outing to a baseball game. The client's diagnosis is Attention-Deficit/Hyperactivity Disorder (Predominantly Hyperactive-Impulsive Type). The goal in this outing is to assist the client in focusing her attention on the game, decrease her tendency to be intrusive, and speak out of turn and butting into other's conversation. The staff member provided rehabilitative service during this activity by redirecting the client when she started to get up out of her assigned seating every other minute and providing positive feedback, verbal kudos while role modeling, and coaching "turn-taking" and other pro-social behaviors with the client. Staff member only claimed for that amount of time she provided rehabilitative services; staff cannot claim for non-treatment time if they choose to remain with the child/youth during non-treatment time. As with all services, the documentation must substantiate and support the service activity that was provided.³⁸

The MHP retains the authority to implement any additional requirements as long as it is above the "minimum" standard.

Claiming Unit (Mental Health Services)

The Claiming unit is the time of the person delivering the service in minutes of time.³⁹

Claiming Considerations. There is no cap or limit on the number of hours per day or the number of days per week that this service activity may be provided, nor is there an annual or lifetime cap or limit. Note: Staff cannot claim for non-treatment time if they choose to remain with the child/youth during non-treatment time.⁴⁰ In no case shall more than 60 minutes of time be re-

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ported 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.⁴¹

Note: Travel time and Documentation time are to be included in the total time as it is linked to the service provided. Documentation time and travel time should be the actual time taken to document the service and travel to and from the service site, not an arbitrary set number of minutes. In those instances when travel time may be longer than the actual service time, best practice may include (in the documentation) how many minutes were face-to-face, how many minutes were spent on documentation and how many minutes were spent on travel; this need not be a separate progress note, but clearly delineated in the service provided to support the time claimed.⁴² You can only claim travel time from an office site, not from a personal residence or other off-time site.

Example: Staff member traveled cross county from his office to the client's home for a total travel time of two-hours and 20 minutes. Staff member checked in with client's mother and reviewed Client Plan and goals for 22 minutes. Upon return to the office, staff member completes his progress note taking approximately 10 minutes. Claim may reflect: 140 minutes (travel) + 22 minutes (Service) + 10 minutes (documentation) for total time claimed 172 minutes. In this context, the amount of total time claimed is supported regardless of the disproportionate travel time in providing the direct service.

1. Prorated Requirement

When claiming for Collateral or other Mental Health or Medication Support Service in a group setting, time claimed must be prorated for each child represented. In addition, when more than one individual is providing this service to more than one child at the same time, the time spent by all those providing the service must be added together to yield the total claimable service.⁴³

Example: In a 30-minute, on-site, Medication Support Group of five parents representing four clients, the Psychiatrist explains the risks and benefits of the different types of anti-depressant medication and potential side-effects, while the Nurse describes the signs and symptoms of depression. The charting time takes twenty minutes:

Client A's Formula

$$\begin{array}{r} 30 \text{ minutes} \times 2 \text{ (Med Support Providers)} \\ + \\ [20 \text{ mins. Documentation}] \\ + \\ 0 \text{ mins. Travel (on-site)} \\ \hline 4 \text{ (clients represented)} \end{array}$$

In this example,
Client A's claim is for 20 minutes

As with any other group, time must be divided equally among the youth with open cases. The total time is multiplied by the number of staff, then it is divided by the identified clients with open cases. Include all clients present in the formula regardless of the funding stream.

2. Medi-Cal versus Non-Medi-Cal Prorating

If a Collateral or other group service is composed of both Medi-Cal and non-Medi-Cal eligible clients, the provider must determine if the rate for the service is the same between the two groups. If the rate is the same, the provider would prorate his/her time equally among the participants. However, if the rates are different, the provider must prorate each separately.⁴⁴



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Example: If a provider delivers 63 minutes of services to a group consisting of 5 Medi-Cal and 2 non-Medi-Cal clients who are reimbursed at different rates, they would:

1. Calculate reimbursement by prorating their time (63 minutes divided by 7 = 9 minutes);
2. Multiply 9 minutes by 5 and apply the Medi-Cal rate to 45 minutes; and
3. Multiply 9 minutes by 2 and apply the non-Medi-Cal rate to 18 minutes.⁴⁵

Lock-outs and Non-reimbursable Settings (Mental Health Services)

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 provided.⁴⁶ While Mental Health Services cannot be claimed separately by day treatment staff during the hours these programs operate, Therapeutic Behavioral Services (TBS) may be claimed during Day Rehabilitation and Day Treatment Intensive if TBS services were pre-authorized by the MHP and delivered by staff other than the Day Rehabilitation and Day Treatment Intensive staff.⁴⁷

An initial MHP payment authorization for counseling, psychotherapy or other similar therapeutic interventions (Mental Health Services as defined in Title 9, CCR, Section 1810.227), excluding services to treat emergency and urgent conditions⁴⁸ and therapeutic behavioral services, that will be provided on the same day that day treatment intensive or day rehabilitation is being provided to the beneficiary. Providers of Mental Health Services, must request MHP payment authorization for continuation of these services on the same cycle required for continuation of Day Treatment Intensive or Day Rehabilitation service program.⁴⁹

Mental Health Services are not reimbursable on

days when Crisis Residential Treatment Services, Inpatient Psychiatric Services or Psychiatric Health Facility Services are reimbursed by Medi-Cal, *except for the day of admission to the facility.*⁵⁰

Mental Health Services are reimbursable on the day of discharge, *following a formal discharge.* Services are not reimbursable on days when the child/youth resided in a setting where the client was ineligible for FFP, e.g., Institute for Mental Disease (IMD), group home, juvenile hall, jail, and other similar settings, unless there is evidence that the court has ordered suitable placement (i.e. post-adjudication for placement).⁵¹

Because Crisis Stabilization is a package program, no other specialty mental health services are reimbursable during the same time period this service is reimbursed, except for Targeted Case Management.⁵²

Staffing (Mental Health Services)

Consistent with scope of practice and as defined by State law, Mental Health Services may be provided by any person determined by the MHP to be qualified to provide the service.

Note: If more than one staff member is providing concurrent mental health services, the contribution of each individual staff member must be unique and unduplicated and clearly described in the documentation. Separate progress notes are recommended, but not required; clear role differentiation must be established in the note. Always follow your MHP guidelines regarding concurrent mental health services.

Co-signature Requirements

Oversight and co-signature of any Mental Health Service activity will be determined according to the MHP's internal quality management pro-

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2.1 Mental Health Services

gram and consistent with state law and within the scope and qualifications of the person providing the Mental Health Service.

Note: Co-signatures can never be used to allow a person to provide a service that is beyond his/her scope of practice and/or qualifications.

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2.2 Medication Support Services

Description

Medication Support Services include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness.⁵³

Service Activities (Medication Support)

Service activities may include, but are not limited to:

- Evaluation of the need for medication;
- Evaluation of clinical effectiveness and side effects;
- Obtaining informed consent;
- Instruction in the use, risks and benefits of, and alternatives for medication;
- Collateral and plan development related to the delivery of the service and/or assessment of the child;
- Prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals; and
- Medication education.

Prescribed (non-mental health) drugs as described in Title 22, Section 51313, and laboratory, radiological, and radioisotope services as described in Title 22, Section 51311, are not the responsibility of the MHPs, except when provided as hospital-based ancillary services.⁵⁴

Physician services as described in Title 22, Sec-

tion 51305, that are not psychiatric services as defined in Section 1810.240, even if the services are provided to treat a diagnosis included in Sections 1820.205 or 1830.205, are not the responsibility of the MHP.⁵⁵

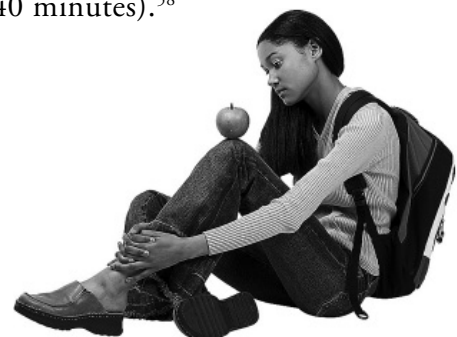
Contact and Site Requirements (Medication Support)

Medication Support Services may be either face-to-face or by telephone with the youth (if age 18 to 21) or with significant support person(s) and may be provided anywhere in the community.⁵⁶

Claiming Unit (Medication Support)

The claiming unit is the time of the person delivering the service in minutes of time. Medication Support Services that are provided within a residential or day program must be claimed as Medication Support Services separately from the residential or day program service.⁵⁷

The maximum amount reimbursable for Medication Support Services in a 24-hour period is 4 hours (240 minutes).⁵⁸



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2.2 Medication Support Services

Note: Medication Support Services is not a lock-out during Day Rehabilitation and Day Treatment Intensive hours of operation.

Note: The Medication Support Service should not exceed the amount of time required for the 50% attendance of the day program (the half-day treatment programs potentially would be the most at risk of this 50% compliance requirement). In other words, when a client in DR or DTI is provided Medication Support Services during DR or DTI service program hours, the client must still attend a minimum of 50% of the DR or DTI program in order to claim for the DR or DTI program concurrent with the claimed Medication Support Service.⁵⁹

Lock-outs (Medication Support)

Medication Support Services are not reimbursable on days when Psychiatric Health Facility or psychiatric inpatient hospitalization services are reimbursed by Medi-Cal, except for the day of admission to the facility.⁶⁰

Medication Support Services can be provided during Residential Treatment, Day Rehabilitation, and Day Treatment Intensive Services.

Medication Support Services that are provided within a residential or day program shall be billed as Medication Support Services separately from the residential or day program service.⁶¹

Staffing (Medication Support)

Medication Support Services must be provided within the scope of practice by any of the following:⁶²

- Physician
- Registered Nurse
- Licensed Vocational Nurse
- Psychiatric Technician
- Pharmacist
- Physician Assistant

Documentation Requirements (Medication Support)

All Medication Support Services require documented evidence of prescribing, administering, dispensing, and monitoring of *psychiatric medications* or biologicals by a qualified medically licensed staff member. Medical students, interns, and nursing students must be supervised by a licensed professional within their scope of practice who are responsible for reviewing and co-signing their documentation.

Medication Support Service activities may include but are not limited to evaluation of the need for medication; evaluation of clinical effectiveness and side effects; the obtaining of informed consent; instruction in the use, risks and benefits of and alternatives for medication; and collateral and plan development related to the delivery of the service and/or assessment of the beneficiary.⁶³

Clients with Medication Support Services in conjunction with limited Case Management may have their annual assessments and client plans completed by the Medication support staff that may be claimed under Medication Support Services. Documentation must support continued medical necessity for Medication Support and limited Case Management services. Like any other client plan, client/caregiver involvement and participation must be documented.⁶⁴ A statement or a signature as evidence of a client/caregiver participation in the Medication Support Service Plan in lieu of an annual Client Plan is required. Signatures on a “Medication Consent Form” does not constitute as evidence of participation.

MHPs can dictate the frequency and the authorization of Medication Support Services as dictated by medical necessity.

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2.3 Day Treatment Intensive Services

Description

Day Treatment Intensive (DTI) is a structured, multi-disciplinary program of therapy that may be an alternative to hospitalization, avoid placement in a more restrictive setting, or maintain the child in a community setting, which provides services to a distinct group of beneficiaries. Services are available at least three hours and less than 24 hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation, and collateral.⁶⁵

Half Day and Full Day DTI Programming⁶⁶

Day treatment intensive 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 child/youth 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 child/youth receives face-to-face services in a program with services available more than four hours per day.
3. Although the child/youth must receive face-to-face services on any full-day or half-day claimed, all service activities during that day are not required to be face-to-face with the child/youth.⁶⁷

Required Service Components

Day Treatment Intensive programs are required to include a daily community/milieu meeting, a therapeutic milieu, contact with significant support person(s),⁶⁸ skill-building groups, adjunc-

tive therapy, and psychotherapy. Day Treatment Intensive may include process groups in addition to psychotherapy.⁶⁹ Additionally, Day Treatment Intensive Programs must have established protocol for responding to a child/youth's mental health crisis (See Section F. below regarding Protocol for Crisis Response)⁷⁰ and a required posted schedule and staffing ratio.⁷¹ Both Day Treatment Intensive and Day Rehabilitation require additional standards of certification by the MHP who will conduct, at a minimum, a review of the provider's program description to ensure the provisions of this chapter are in force; for individual and group providers, this review will not be required to be on-site, however for organizational providers, this review must be included in the required on-site review.⁷²

Therapeutic Milieu

Required Day Treatment therapeutic milieu components.⁷³

Day Treatment Intensive programs are required to have a ***“Therapeutic Milieu”***⁷⁴ that:

- Provides the foundation for the provision of day treatment program and differentiates these services from other specialty mental health services;
- Includes a therapeutic program that is structured by well-defined service components with specific activities performed by identified staff;
- Includes a requirement for **“continuous hours of operation”** which does not preclude short breaks (for example, a school recess period) between milieu activities. A lunch or dinner break may also be appropriate, depending on the program's schedule. These breaks do not count towards the total hours of operation of the day program for purposes of deter-

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2.3 Day Treatment Intensive Services

- mining minimum hours of service;⁷⁵
- Enables the therapeutic milieu to be, at least, an average of three hours for full-day programs and an average of two hours per day for half-day programs⁷⁶ (average in a day);
- Creates a supportive and nurturing interpersonal environment that teaches, models, and reinforces constructive interaction;
- Supports peer/staff feedback to children/youth on strategies for symptom reduction, increasing adaptive behaviors, and reducing subjective distress;
- Empowers children/youth through involvement in the program (such as the opportunity to lead community meetings and to provide feedback to peers)

and a supportive environment to take risks; and

- Supports behavior management interventions that focus on teaching self-management skills that children/youth may use to control their own lives, to deal effectively with present and future problems, and to function well with minimal or no additional therapeutic intervention.

A. Skill-Building Therapies

Skill-building groups: Staff help clients to identify barriers/obstacles related to their psychiatric/psychological experiences and, through the course of group interaction, become better able to identify skills that address symptoms and behaviors and to increase adaptive behaviors.⁷⁷

Skill-Building Group Example

During a Community meeting, led by one of the day treatment program children, youth shared their mutual experience regarding family outings that typically ended with fighting, arguing and sometimes, physical violence. It is suggested by a day treatment program staff member that they should plan an outing, but before going on that outing, they should stage a mock outing about the do's and don'ts regarding behaviors that may lead to the fighting, arguing and violence.

The children, with the day treatment program staff, then stage a mock outing "role playing" how they and others previously experienced dysfunctional outings and what triggered the fighting and arguing in the past.

The day treatment program staff help guide the children in role playing alternative behaviors (such as not responding when teased by a peer by counting to ten; or by complimenting a peer instead of teasing a peer when irritated).

The group then discussed their experience and provided mutual feedback on how they think they performed with their new found behaviors in a supportive environment reinforced by the day treatment program staff.



B. Adjunctive Therapies

Staff and clients participate in non-traditional therapy that utilizes self-expression (art, recreation, dance, music, etc.) as the therapeutic intervention. Participants do not need to have any level of skill in the area of self-expression, but rather be able to utilize the modality to develop or enhance skills directed towards client plan goals.⁷⁸

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Adjunctive Therapy Group Example

On today's day treatment program schedule, staff have planned a "basketball workshop group." The goal of this adjunctive exercise is to increase coordination, self-confidence, increase focus, increase self-esteem, and increase cooperation by emphasizing the ability to cooperate, share and take turns and express oneself in a constructive supportive atmosphere.

Pass-Relay Exercise

- The goal of the exercise is to share and cooperate with others by passing the basketball to another peer and telling that peer what he/she likes about that peer and to do so in less than ten seconds while standing still.
- Once having completed the first round, the next exercise is for the peers to pass the basketball to each other and name at least one thing they like about themselves
- The degree of difficulty is increased as peers are asked to repeat the exercise by having two relay teams that have to run and dribble the ball to the other team and provide two compliments or positive actions before passing the ball to another peer in an allotted time.
- Second half of the basketball activity involves the youth taking turns to shoot at the basket and to name one behavior or situation they would like to change in their life.
- The degree of difficulty is increased whereas in order to have a turn to shoot the ball again the youth is to share how they may change that behavior or situation.

C. Process Groups⁷⁹

Staff facilitate these groups to help clients develop the skills necessary to deal with their individual problems/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. Process groups are based on the premise that much of human behavior and feeling involves the individual's adaptation and response to other people and that the group can assist individuals in making necessary changes by means of support, feedback and guidance. It is a process carried out by informally organized groups that seek change.

Process Group Example

During the day treatment program's regularly scheduled Process Group titled "Problem Solving", the children democratically vote on one out of three staff prepared topics to tackle.

The topic that received the most votes today was, "What my brother/sister does that drives me crazy!"

The day treatment program staff assisted one child volunteer to write a list of sibling behaviors that drive them crazy on a whiteboard during an open sharing session. Once having formulated the list, the day treatment program staff helps another child "take a vote" from the list what most of the members of the group share in common. Next, the children share problem solving strategies on a whiteboard what they had done to avoid a confrontation with their sibling or how they successfully handled a negative sibling behavior that "drove them crazy"

Finally, the group votes and provides feedback on which strategy might be the best of the ones suggested by their peers with the idea that they would change a maladaptive behavior with this new strategy.

D. Psychotherapy⁸⁰

Psychotherapy includes the use of psychosocial

methods within a professional relationship to assist the child or children to achieve a better

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2.3 Day Treatment Intensive Services

psychosocial adaptation, to acquire greater human realization of psychosocial potential and adaptation, and/or 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. This service may only be provided to the child/youth by licensed, registered, or waived staff practicing within their scope of practice. Psychotherapy does not include physiological interventions, including medication intervention. Psychotherapy is a required component of Day Treatment Intensive programming.

E. Community/Milieu Meetings⁸¹

Community meetings are to occur, at a minimum, once a day to address issues pertinent to the continuity and effectiveness of the therapeutic milieu. The community meeting may address relevant items including, but not limited to what the schedule for the day will be, current events, individual issues clients or staff wish to discuss to elicit support of the group, conflict resolution within the milieu, planning the day, the week, or for special events, old business from previous meetings or from previous day treatment experiences, debriefing, or wrap up.

Community meetings shall actively involve staff and clients and include one staff person whose scope of practice includes psychotherapy for Day Treatment Intensive programs.⁸²

F. Protocol in Crisis Response to Mental Health Crisis⁸³

A requirement for Day Treatment Intensive is an established protocol for responding to children/

youth experiencing a mental health crisis. Components of this protocol must include:

1. The assurance and availability of appropriately trained and qualified staff;
2. Protocols or procedures established on how to address a crisis situation;
3. Referrals for Crisis Intervention, Crisis Stabilization, or other specialty mental health services to address a child's urgent or emergent psychiatric condition; and
4. The capacity to handle a crisis until the child/youth is linked to these services if located outside of the Day Treatment program.

Contact and Site Requirements (Day Treatment Intensive)

Day Treatment Intensive Services shall have a clearly established site for services, although all services need not be delivered at that site.⁸⁴ Additionally, services must be provided face-to-face⁸⁵ and provided during continuous hours of operation (excluding short breaks between milieu activities and appropriate breaks for meals); these breaks do not count towards the total hours of operation when determining the minimum hours of service.⁸⁶ A clear audit trail is required for accounting dedicated staff ratios and program operations as well as required curriculum schedule (community meetings, verification of therapeutic milieu, etc.) that is made available to the children, and as appropriate, to their families, caregivers, or significant support persons. This detailed weekly schedule must include when and where the activities are scheduled and the program staff, their qualifications, and their scope of responsibilities including who will be providing the services detailed on the schedule.⁸⁷

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Regarding TBS and Day Treatment Intensive program, the TBS coach may be in the same room and providing TBS services; however, TBS staff cannot be counted in staffing for the Day Treatment program while assigned as the TBS staff member.⁸⁸

“Contact with a Significant Support Person” is required in Day Treatment Intensive Programs. At least, one contact (face-to-face or by an alternative method such as telephone) is to be made each month with a family member, caregiver, or other significant support person who is legally responsible adult for the child/youth.⁸⁹

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.⁹⁰

Note: Contact with a Significant Support Person must be documented in the chart. If contact is made by letter, best practice recommends that a copy of the correspondence be placed in the chart as substantiation of compliance. The practice of due diligence in assuring confidentiality should be made whenever Protected Health Information (PHI) is sent to a Significant Support Person.

If contact is made by phone, charting should include what transpired in the communication with the Significant Support Person and what actions are being taken in supporting the client’s reintegration into the community.

Claiming Unit (Day Treatment Intensive)

“Full Day” Day Treatment Intensive service programs shall be claimed as full day service for each day in which the child receives face-to-face services in a structured program⁹¹ (see Service Activities) and attends at least 50% of the scheduled

program. Full Day Intensive services are defined as more than four hours per day.⁹²

“Half Day” Day Treatment Intensive services programs shall be claimed as half day service for each day in which the child receives face-to-face services in a structured program⁹³ and attends more than 50% of the scheduled program. Half Day Intensive services are defined as services available at least three hours, up to four hours per day.

When a child meets medical necessity for day rehabilitation and no rehabilitation program is reasonably available, an MHP may authorize a program certified as Day Treatment Intensive which will be billed and reimbursed as Day Rehabilitation.⁹⁴

Note: In the event the child/youth attends less than 50% of either Full or Half Day Intensive services in a single day, no claim shall be made by the provider.⁹⁵

Authorization

Initial authorization from the MHP for Day Treatment Intensive is required prior to the submission of claims for this service.⁹⁶ Continued services must be reauthorized at least, every three months.⁹⁷ Adjunct specialty mental health service providers shall be on the same concurrent authorization cycle as the Day Treatment Intensive (every three months).⁹⁸

MHP initial authorization is required for counseling, psychotherapy or other similar therapeutic interventions that meet the definition of Mental Health Services (excluding emergency and urgent conditions) that will be provided on the same day as Day Treatment Intensive.⁹⁹ TBS services, with MHP authorization, may be provided concurrently as a supplemental service

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2.3 Day Treatment Intensive Services

with Day Treatment Intensive Services, but must not be included as part of the staffing ratio for the Day Treatment Intensive program.¹⁰⁰

Note: If authorized by the MHP, Mental Health Services may be provided on the same day as Day Treatment Intensive and Day Rehab programs outside of program hours.

Lock-outs (Day Treatment Intensive)

Day Treatment Intensive services are not reimbursable on days when Crisis Residential, Psychiatric Inpatient, or Psychiatric Health Facility Services are reimbursed, except for the day of admission to those services.¹⁰¹

Mental Health Services are not reimbursable when provided by Day Treatment Intensive staff during the same time period that Day Treatment Intensive services are provided.¹⁰²

Two full-day or one full-day and one half-day or two half-day programs may not be provided to the same child/youth on the same day.¹⁰³

Note: Medication Support Services are NOT a lock-out during the hours of DTI and Day Rehab and can be provided during the hours of DTI and Day Rehab if authorized and appropriate.

Staffing (Day Treatment Intensive)

At a minimum, there must be an average ratio of at least one person, per eight children/youth, whose time is dedicated to the Day Treatment Intensive program during the hours of operation from the following list providing Day Treatment Intensive services.¹⁰⁴

1. Physicians

2. Licensed/waivered/registered Psychologists
3. Licensed Clinical Social Workers (LCSW) or related registered professionals (ASW)
4. Marriage and Family Therapists (MFT) or related registered professionals (MFT-Intern [IMF])
5. Registered Nurses (RN)
6. Licensed Vocational Nurses (LVN)
7. Psychiatric Technicians (PT)
8. Occupational Therapists (OT)
9. Mental Health Rehabilitation Specialists as defined in Section 630 (MHRS)

The average ratio of day program staff to children/youth in the day program is based on the average number of day program children/youth (Medi-Cal and Non-Medi-Cal) participating in the continuous hours of operation of the day treatment program *on that day*. Staff providing individual services, including individual therapy to day program children/youth may continue to be counted in the staffing ratio during the time they are in individual therapy in addition to the time they are present and available in the therapeutic milieu.¹⁰⁵

Persons providing services in Day Treatment Intensive programs serving more than 12 children/youth, shall include at least one person from two of the following staff categories:¹⁰⁶

1. Physicians
2. Licensed/waivered/registered Psychologists
3. Licensed Clinical Social Workers (LCSW) or related registered professionals (ASW)
4. Marriage and Family Therapists (MFT) or related registered professionals (MFT-Intern [IMF])
5. Registered Nurses (RN)
6. Licensed Vocational Nurses (LVN)

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7. Psychiatric Technicians (PT)
8. Occupational Therapists (OT)
9. Mental Health Rehabilitation Specialist as defined in Section 630 (MHRS)

The average ratio of Day Treatment Intensive program staff to children/youth in the day program is based on the average number of day program children/youth (Medi-Cal and Non-Medi-Cal) participating in the continuous hours of operation of the program on that day. DTI staff providing individual services, including individual therapy to children/youth in the program, may be counted in the staffing ratio during the time they are in individual therapy in addition to the time they are present and available in the therapeutic milieu. Persons providing Day Treatment Intensive services who do not participate in the entire Day Treatment Intensive session, whether full-day or half-day, may be utilized according to program need, but shall only be included as part of the above ratio formula on a pro rata basis based on the percentage of time in which they participated in the session.¹⁰⁷

Note: Staffing requirements will be expanded to require at least one staff person to be present and available to the group in the therapeutic milieu for all scheduled hours of operation. For Day Treatment Intensive, staffing must include at least one staff person whose scope of practice includes psychotherapy.¹⁰⁸

The MHP shall ensure that there is a clear audit trail of the number and identity of the persons who provide Day Treatment Intensive services and function in other capacities.¹⁰⁹

Documentation Requirements (Day Treatment Intensive)

Day Treatment Intensive requires a daily progress note on activities and a weekly clinical summary reviewed and signed or co-signed by one of the following Licensed Practitioner of the Healing Arts (LPHA) who is either a staff member in the Day Treatment Intensive program or the person directing the service:¹¹⁰

1. Physician
2. Licensed/waivered/registered Psychologist
3. Licensed Clinical Social Worker (LCSW) or related registered professional (ASW)
4. Marriage Family Therapist or related registered professional (MFT-Intern [IMF])
5. Registered Nurse (RN)

Note: Day Treatment Intensive and Day Rehabilitation must have and make available to clients and, as appropriate, to their families, caregivers or significant support persons a detailed written weekly schedule that identifies when and where the service components of program will be provided and by whom. The written weekly schedule will specify the program staff, their qualifications, and the scope of their responsibilities.¹¹¹



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2.4 Day Rehabilitation

Description

Day Rehabilitation is a structured program of rehabilitation and therapy to improve, maintain or restore personal independence and functioning, consistent with requirements for learning and development, which provides services to a distinct group of children who are EPSDT beneficiaries. Services are available at least three hours and less than 24 hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation, and collateral.¹¹²

Half Day and Full Day Rehabilitation Programming

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 child/youth 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 child/youth receives face-to-face services in a program with services available more than four hours per day.
3. Although the child/youth must receive face-to-face services on any full-day or half-day claimed, all service activities during that day are not required to be face-to-face with the child/youth.¹¹³

Note: Providers must request an initial MHP payment authorization for Day Rehabilitation. Providers must request prior authorization when Day Rehabilitation will be provided for more than five days per week.¹¹⁴ Continued authorization for Day Rehabilitation programs is required, at least, every six months.¹¹⁵ Adjunct specialty mental health service providers shall be on the same concurrent authorization cycle as the Day Rehabilitation program (i.e., every six months).¹¹⁶

Required Service Components

Day Rehabilitation programs must also provide developmentally- and age-appropriate programs or service activities that help children to develop skills necessary to deal with their individual problems using a group process to provide peer interaction and feedback. Staff could employ behaviorally focused interventions in the required therapeutic treatment milieu (See Day Treatment Intensive, under *“Therapeutic Milieu”*) by redirecting, modeling, providing token economies or contingency contracting to reinforce and support adaptive behavioral change.¹¹⁷

Therapeutic Milieu

Required Day Rehabilitation Therapeutic Milieu components.¹¹⁸

Day Rehabilitation programs are required to have a *“Therapeutic Milieu”*¹¹⁹ that:

- Provides the foundation for the provision of day program and differentiates these services from other specialty mental health services;
- Includes a therapeutic program that is structured by well-defined service components with specific activities performed by identified staff;
- Takes place during continuous scheduled hours of operation for the program

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(more than four hours for a full-day program and a minimum of three hours for a half-day program, not including breaks, snacks or lunch);

- Therapeutic Milieu must be at least, an average of three hours for full-day programs and an average of two hours per day for half-day programs;¹²⁰
- Creates a supportive and nurturing interpersonal environment that teaches, models, and reinforces constructive interaction;
- Supports peer/staff feedback to children/youth on strategies for symptom reduction, increasing adaptive behaviors, and reducing subjective distress;
- Empowers children/youth through involvement in the program (such as the opportunity to lead community meetings and to provide feedback to peers) and a supportive environment to take risks; and
- Supports behavior management interventions that focus on teaching self-management skills that children/youth may use to control their own lives, to deal effectively with present and future problems, and to function well with minimal or no additional therapeutic intervention.

A. Process Groups

Process groups are groups facilitated by staff to help children develop the skills they need 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. Day rehabilitation may include psychotherapy instead of process groups

or in addition to process groups.¹²¹ (See Day Treatment Intensive *Process Group Example*)

B. Skill-Building Groups

Skill-Building Groups are groups in which staff members help children to identify barriers related to their psychiatric and psychological experiences and, through the course of group interaction, become better able to identify skills that address symptoms and behaviors and to increase adaptive behaviors.¹²² (See Day Treatment Intensive, under *Skill-Building Group Example*)

C. Adjunctive Therapies

Adjunctive Therapies are non-traditional therapies in which both staff and EPSDT beneficiaries participate. These are therapies that utilize self-expression, such as art, recreation, dance, music, etc., as therapeutic intervention. The children do not need to have any level of skill in the area of self-expression, but rather must be able to utilize the modality to develop or enhance skills directed toward client plan goals.¹²³ (See Day Treatment Intensive, under *Adjunctive Therapy Group Example*)

D. Community/Milieu Meetings¹²⁴ (Day Rehabilitation)

Community Meetings are to occur at a minimum once a day, to address issues pertinent to the continuity and effectiveness of the Therapeutic Milieu. These Community Meetings shall actively involve staff and clients and include one of the following staff persons:¹²⁵

1. Physician
2. Licensed/waivered/registered psychologist
3. Licensed Clinical Social Worker (LCSW) or related registered professionals (ASW)
4. Marriage and Family Therapist (MFT)

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or related registered professionals (MFT-Intern [IMF])

5. Registered Nurse (RN)
6. Licensed Vocational Nurse (LVN)
7. Psychiatric Technician (PT)
8. Mental Health Rehabilitation Specialist (MHRS)

The Community Meeting may address relevant items including, but not limited to, what the schedule for the day will be, current events, individual issues clients or staff wish to discuss to elicit support of the group, conflict resolution within the milieu, planning the day, the week, or for special events, old business from previous meetings or from previous day treatment experiences, debriefing, or wrap-up.

E. Protocol in Crisis Response to Mental Health Crisis¹²⁶

A requirement for Day Rehabilitation (and Day Treatment Intensive programs as well), of an established protocol for responding to children/youth experiencing a mental health crisis is required. Components of this protocol must include:

- The assurance and availability of appropriately trained and qualified staff;
- Protocols or procedures established on how to address a crisis situation;
- Referrals for Crisis Intervention, Crisis Stabilization, or other specialty mental health services to address child's urgent or emergent psychiatric condition; and
- The capacity to handle a crisis until the child/youth is linked to these services if located outside of the Day Rehabilitation program.

Contact and Site Requirements (Day Rehabilitation)

Day Rehabilitation programs shall have a clearly established site for services, although all services need not be delivered at that site.¹²⁷ Additionally, services must be provided face-to-face¹²⁸ and provided during continuous hours of operation (excluding short breaks between milieu activities and appropriate breaks for meals); these breaks do not count towards the total hours of operation when determining the minimum hours of service.¹²⁹ A clear audit trail is required for accounting dedicated staff ratios and program operations as well as required curriculum schedule (community meetings, verification of therapeutic milieu, etc.) that is made available to the children, and as appropriate, to their families, caregivers or significant support persons. This detailed weekly schedule must include when and where the activities are scheduled and the program staff, their qualifications, and their scope of responsibilities including who will be providing the services detailed on the schedule.¹³⁰

“Contact with a Significant Support Person”

is required in Day Rehabilitation Programs. At least, one contact (face-to-face or by an alternative method such as the telephone) is to be made each month with a family member, caregiver, or other significant support person who is legally responsible adult for the child/youth.¹³¹ Program staff may be required to spend time on day rehabilitation activities outside the hours of operation and therapeutic milieu, e.g., time for travel, documentation, and caregiver contacts.¹³²

The contacts and involvement should focus on the role of the significant support person in supporting the client's community reintegration.¹³³

Day Rehabilitation programs are required to

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have a “Therapeutic Milieu.” (See “Therapeutic Milieu” definition under Day Treatment Intensive Program)

Claiming Unit (Day Rehabilitation)

When a child meets medical necessity for Day Rehabilitation and no rehabilitation program is reasonably available, an MHP may authorize a program certified as Day Treatment Intensive which is claimed and reimbursed as Day Rehabilitation.¹³⁴ Note: The Day Program must be “dually” certified in both Day Rehabilitation and Day Treatment Intensive.

Authorization

Initial authorization from the MHP for Day Rehabilitation is required prior to the submission of claims for this service. Continued services must be reauthorized at least, every six months.¹³⁵ Adjunct specialty mental health service providers shall be on the same concurrent authorization cycle as the Day Rehabilitation (every six months).¹³⁶

MHP initial authorization is required for counseling, psychotherapy, or other similar therapeutic interventions that meet the definition of Mental Health Services (excluding emergency, urgent conditions, and TBS) that will be provided on the same day as Day Rehabilitation.¹³⁷

Continued services must be reauthorized at least, every six months.¹³⁸ Adjunct specialty mental health service providers shall be on the same concurrent authorization cycle as the Day Rehabilitation program (every six months).¹³⁹

Note: MHPs retain their authority to establish standards for Day Treatment Intensive and Day Rehabilitation above the minimum standards described.¹⁴⁰

Lock-outs (Day Rehabilitation)

Day Rehabilitation services are not reimbursable on days when Crisis Residential, Psychiatric Inpatient, or Psychiatric Health Facility Services are reimbursed, except for the day of admission to those services.¹⁴¹

Mental Health Services are not reimbursable when provided by Day Rehabilitation staff during the same time period that Day Rehabilitation services are provided.¹⁴²

Day Rehabilitation programs may provide only one-full day or two half days of Day Rehabilitation services daily. A child may not attend two half day programs on the same day.¹⁴³

Note: MHP initial authorization is required for counseling, psychotherapy or other similar therapeutic interventions that meet the definition of Mental Health Services (excluding emergency, urgent conditions and TBS) that will be provided on the same day as Day Rehabilitation services.¹⁴⁴

Staffing (Day Rehabilitation)¹⁴⁵

At a minimum there must be an average ratio of at least one person, whose time is dedicated to the Day Rehabilitation program, from the following list providing Day Rehabilitation services to ten children/youth during the period the program is open.

1. Physicians
2. Licensed/waivered/registered Psychologists
3. Licensed Clinical Social Workers or related registered professionals (ASW)
4. Marriage and Family Therapists (MFT) or related registered professionals (MFT-Intern [IMF])
5. Registered Nurses (RN)
6. Licensed Vocational Nurses (LVN)

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7. Psychiatric Technicians (PT)
8. Occupational Therapists (OT)
9. Mental Health Rehabilitation Specialists as defined in Section 630 (MHRS)

For Day Rehabilitation programs serving more than 12 children/youth, the program shall include at least two of the following:

1. Physicians
2. Licensed/registered Psychologists
3. Licensed Clinical Social Workers or related registered professionals (ASW)
4. Marriage and Family Therapists (MFT) or related registered professionals (MFT-Intern [IMF])
5. Registered Nurses (RN)
6. Licensed Vocational Nurses (LVN)
7. Psychiatric Technicians (PT)
8. Occupational Therapists (OT)
9. Mental Health Rehabilitation Specialists (MHRS)

The average ratio of Day Rehabilitation program staff to children/youth in the day program is based on the average number of Day Rehabilitation program children/youth (Medi-Cal and Non-Medi-Cal) participating in the continuous hours of operation of the Day Rehabilitation program *on that day*. Staff providing individual services, including individual therapy to Day Rehabilitation program children/youth may continue to be counted in the staffing ratio during the time they are in individual therapy in addition to the time they are present and available in the therapeutic milieu.¹⁴⁶

Documentation Requirements (Day Rehabilitation)

Day Rehabilitation services require a weekly progress note on activities.¹⁴⁷

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2.5 Therapeutic Behavioral Services

Description

Therapeutic Behavioral Services (TBS) are *supplemental* specialty mental health services under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit.¹⁴⁹ TBS is an intensive, individualized, one-to-one, short-term, outpatient treatment intervention for beneficiaries up to age 21 with serious emotional disturbances (SED) who are experiencing a stressful transition or life crisis and need additional short-term specific support services to accomplish outcomes specified in the written treatment plan. For a child/youth to be eligible for TBS, a mental health provider must find that

in his or her clinical judgment, either that:

- a. It is highly likely that without the additional short-term support of TBS the child/youth will need placement in a Rate Classification Level (RCL) 12 through 14 facility or a locked facility for the treatment of mental health needs, or will need acute psychiatric hospital inpatient services, psychiatric health facility services, or crisis residential treatment services; or
- b. The child/youth needs the additional support of TBS to enable a transition from any of those levels to a lower level

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2.5 Therapeutic Behavioral Services

of residential care. A significant component of this service activity is having the staff person on-site and immediately available to intervene for a specified period of time.¹⁴⁹

EPSDT eligible children or youth must receive these services if they have an included diagnosis, their condition would not be responsive to physical healthcare based treatment, and the service will *correct or ameliorate the diagnosed mental illness*.¹⁵⁰

Note: TBS Eligibility requires clients to be Full-Scope Medi-Cal beneficiaries under age 21 years who meet MHP medical necessity criteria.¹⁵¹

Criteria for Certified Class Membership and Need for Service

EPSDT eligible children or youth must be a member of the following certified class to qualify for TBS services:

Class Criteria

- Child/Youth placed in a group home facility of RCL 12 or above and/or locked treatment facility for the treatment of mental health needs? *or*
- Child/Youth is being considered by the county for placement in a facility described above?
- Child/Youth has undergone, at least, one emergency psychiatric hospitalization related to his/her current presenting disability within the preceding 24 months?
or
- Child/Youth previously received TBS while a member of the certified class?¹⁵²

Need Criteria

Additionally, the Child/Youth must meet the condition that it is highly likely in the clinical judgment of the mental health provider that without additional short term support of TBS:

- The Child/Youth will need to be placed in a higher level of residential care, including acute care, because of changes in the child/youth's behaviors or symptoms that places a risk of removal from the home or residential placement? *or*
- The child/youth needs this additional support to transition to a lower level of residential placement or return to the natural home?¹⁵³

TBS is not a “stand alone” service, and is 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 lower level of placement.¹⁵⁴

TBS may be continued even after a child has met the behavior goals in his or her TBS plan when TBS still meets Medical Necessity to stabilize the child's behavior and reduce the risk of regression.¹⁵⁵

TBS includes, but is not limited to:

1. Making collateral contacts with family members, caregivers, and other significant support person(s) in the life of the child/youth; and
2. Developing a plan clearly identifying specific target behaviors to be addressed and the interventions that will be used to address the target behaviors.¹⁵⁶

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Conditions Under Which TBS Is Not Reimbursable

1. TBS cannot be provided solely:¹⁵⁷
 - 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
- Furthermore, TBS is not for:¹⁵⁸
2. Children/youth who can sustain non-impulsive self-directed behavior, handle themselves appropriately in social situations with peers, and who are able to appropriately handle transitions during the day;
3. Children/youth who will never be able to sustain non-impulsive self-directed behavior and engage in appropriate community activities without full-time supervision;
4. Children/youth who are currently admitted on an inpatient psychiatric hospital, psychiatric health facility, nursing facility, IMD, or crisis residential program;
5. On-Call Time for the staff person providing TBS;
6. TBS staff providing TBS to a child or youth may not provide services to another child or youth during the time period authorized for TBS;
7. Accompanying a child or youth who is being transported may be reimbursable, depending on the specific, documented,

circumstances; or

8. TBS is not intended to supplant the child or youth's other mental health services provided by other mental health staff.¹⁵⁹

Service Activities (TBS)

The critical distinction between TBS and other rehabilitative Mental Health Services is that a significant component of this service activity is having the staff person on-site and immediately available to intervene for a specified period of time.¹⁶⁰

Note: TBS cannot duplicate other funding for the same service.

For example, some group homes RCL 13 and 14 are required to provide one-to-one assistance as part of the mental health certification. If TBS is provided in a group home with such a requirement, the MHP must clearly specify that this service is in addition to and *different* from the services provide through the group home's one-to-one staffing. There must be a clear audit trail to ensure there is not duplicate funding.¹⁶¹

Contact and Site Requirements (TBS)

The person providing TBS is available on-site to provide individualized *one-to-one* behavioral assistance and one-to-one interventions to accomplish outcomes specified in the written treatment plan.¹⁶²

Therapeutic Behavioral Services must be provided by a licensed practitioner of the healing arts or trained staff members who are under the direction of a licensed practitioner of the healing arts.¹⁶³

TBS can be provided anywhere in the community, at home, school, and other places such as after-

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2.5 Therapeutic Behavioral Services

school programs and organized recreation programs, except during lock-outs (see below).¹⁶⁴ As with Mental Health Services, TBS can be provided either face-to-face or by telephone, however, a significant component of this service activity is having the staff person on-site and immediately available to intervene for a specified period of time.¹⁶⁵

The person providing TBS should be trained in behavioral analysis with an emphasis on positive behavioral interventions.¹⁶⁶

Claiming Unit (TBS)

The claiming unit is the time of the person delivering the service in minutes of time.¹⁶⁷

TBS designated time periods may vary in length and may be up to 24 hours a day, depending upon the needs of the child/youth.¹⁶⁸

Note: The TBS coach may accompany the child during the Day Treatment program. The child/youth must be in attendance and be an active participant of the Day Treatment program at least 50% of the scheduled hours of operation for that day if claiming attendance during Day programs.¹⁶⁹

Lock-outs (TBS)

TBS is not reimbursable on days when Crisis Residential Treatment Services, Inpatient Psychiatric Services, or Psychiatric Health Facility Services are reimbursed by Medi-Cal, except for the day of admission to the facility.¹⁷⁰

TBS (and any other service) is not reimbursable on days when the child/youth resided in a setting where the client was ineligible for FFP, e.g., Institute for Mental Disease (IMD), juvenile hall (unless evidence that the court has

ordered placement [post-adjudication for placement] in a group home or other setting than a correctional institution, jail, and other similar settings).¹⁷³

Because Crisis Stabilization is a package program, TBS is not reimbursable when provided during the same time period that Crisis Stabilization - Emergency Room or Crisis Stabilization - Urgent Care services are reimbursed by Medi-Cal.¹⁷²

Staffing (TBS)

TBS is a direct one-to-one service. One-to-one services 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 crisis intervention, crisis stabilization, day rehabilitation, or day intensive services.¹⁷³ One-to-one services must be provided either by an LPHA or trained staff who are under the direction of an LPHA.

Direct TBS providers delivering TBS in group homes may not be counted in the group home staffing ratio.

Note: Staff qualifications for TBS One-to-one services will be determined by the MHP.¹⁷⁴ TBS providers meet the organizational provider qualifications already established.¹⁷⁵

Co-signature Requirements

Oversight and co-signature of any Mental Health Service activity, including TBS, will be determined according to the MHP's internal quality management program and consistent with state law and within the scope and qualifications of the person providing the Mental Health Service.

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Documentation Requirements (TBS)¹⁷⁶

TBS has very exacting documentation requirements for the provision of this intensive service. See General Documentation Requirements in Chapter 6 regarding “Documentation of Services” in addition to this section.

Authorization¹⁷⁷

1. Initial TBS Authorization

- a. MHP shall not approve an initial MHP payment authorization request for direct one-to-one TBS that:
 - i. Exceeds 30 days if the provider is requesting authorization of direct one-to-one TBS that exceeds 12 hours per day;
 - ii. Exceeds 60 days if the provider is requesting authorization of direct one-to-one TBS that is less than or equal to 12 hours per day;
- b. The MHP shall permit providers to submit initial MHP payment authorization requests that include a TBS client plan. See “TBS Client Plan Documentation” below.

2. Reauthorization

- a. The MHP shall not approve an MHP payment authorization request for reauthorization of TBS that exceeds 30 days if the provider is requesting authorization of direct one-to-one TBS that exceeds 12 hours per day or exceeds 60 days if the provider is requesting authorization of direct one-to-one TBS that is less than or equal to 12 hours per day.
- b. The MHP shall base decisions on requests for reauthorization of TBS

on clear documentation in the Client Plan. See “TBS Client Plan Documentation” and “TBS Progress Note Documentation” below and the following:

- i. The child/youth’s progress towards the specific goals and timeframes of the TBS client plan.
 - ii. A strategy to decrease the intensity of services and/or to initiate the transition plan and/or terminate services when TBS has been effective for the beneficiary in making progress towards specified measurable outcomes identified in the TBS plan or the beneficiary has reached a plateau in benefit effectiveness. A strategy to terminate services shall consider the intensity and duration of TBS necessary to stabilize the beneficiary’s behavior and reduce the risk of regression.
3. If applicable, the beneficiary’s lack of progress towards the specific goals and timeframes of the TBS client plan and changes needed to address the issue. If the TBS being provided to the beneficiary has not been effective and the beneficiary is not making progress as expected towards identified goals, the alternatives 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.
 4. The review and updating of the TBS client plan as necessary to address any significant changes in the beneficiary’s environment (e.g., a change in resi-

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dence).

5. The provision of skills and strategies to parents/caregivers to provide continuity of care when TBS is discontinued.¹⁷⁸

MHPs must consider the provider's evaluation of the intensity and duration of TBS necessary to stabilize the child/youth's behavior and reduce the risk of regression in making decisions on requests for reauthorization of TBS.¹⁷⁹

An MHP approval of a fourth MHP payment authorization request for a child/youth requires the Provider to submit 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. This TBS summary must be submitted to the Mental Health Director for the MHP responsible for the child/youth's care and to the Department of Mental Health at 1600 9th Street, Room 100, Sacramento, CA 95814, within five working days of the fourth TBS authorization decision.¹⁸⁰

Note: An MHP Licensed Practitioner of the Healing Arts (LPHA) provides the initial authorizations and subsequent reauthorization decisions regarding TBS.¹⁸¹ In the event the a TBS authorization is denied, modified, deferred, reduced or terminated, a Notice of Action (NOA) is completed by the MHP and is sent to the client/legal or de facto caregiver/guardian and the Provider (if applicable).¹⁸²

TBS Assessment Documentation¹⁸³

Assessments require that the provider documents the following:

- Must be comprehensive enough to identify that the child or youth meets medical necessity criteria, is a full-scope

Medi-Cal beneficiary under 21 years of age, and is a member of the certified class; that there is a need for specialty mental health services in addition to TBS; and that the child or youth has specific behaviors and/or symptoms that require TBS;

- Identify the child/youth's specific behaviors and/or symptoms that jeopardize continuation of the current residential placement or put the child at risk for psychiatric hospitalization 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/youth in the existing 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 TBS services have been successful and can be reduced or terminated;
- Identify skills and adaptive behaviors

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that the child/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; and

- Initial and on-going assessments of the need for TBS may be accomplished as part of an overall assessment of a child or youth's mental health needs or through a separate assessment specifically targeted to determining whether TBS is needed.¹⁸⁴

TBS Client Plan Documentation

TBS client plans can either be separate plans or a component of a more comprehensive plan (that includes other specialty mental health services).

The TBS plan is intended to provide clinical direction for short-term intervention(s) to address very specific behaviors and/or symptoms of the child or youth that were identified in the TBS Assessment. Concrete identification of behaviors and interventions in the assessment process is the key component necessary to developing an effective TBS Client Plan.

TBS Plans should document the following.¹⁸⁵

1. The TBS client plan is intended to provide clinical direction for one or a series of short-term intervention(s) to address very specific behaviors and/or symptoms of the beneficiary as identified by the assessment process;
2. Clearly identifies specified behaviors and/or symptoms that jeopardize the residential placement or transition to a lower level of residential placement and that will be the focus of TBS;
3. Includes a specific plan of intervention for each of the targeted behaviors or symptoms identified in the assessment and the client plan which is developed with the family, if available, and appropriate;
4. Includes 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;
5. Identifies a specific way to measure the effectiveness of the intervention at regular intervals and documentation of changes in planned interventions when the original plans are not achieving expected results;
6. Includes a transition plan that describes in measurable terms how and when TBS will be decreased and ultimately discontinued, either when the identified benchmarks (which are the objectives that are met as the beneficiary progresses towards achieving client 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 developing the plan, are not reasonably expected to be achieved. This plan should address assisting parents/caregivers with skills and strategies to provide continuity of care when TBS is discontinued;
7. As necessary, includes 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; and
8. If the beneficiary is between 18 and 21

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years of age, includes notes regarding any special considerations that should be taken into account, e.g., the identification of an adult case manager.

Note: TBS Client Plan Addendums should document any significant changes in the child or youth's environment since the initial TBS Client Plan or that TBS 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 they have considered alternatives, and only requested additional hours/days for TBS based on the documented expectation that the additional time will be effective.¹⁸⁶

notes describe interventions provided and circumstances requiring intervention, not purely descriptive, passive reporting from staff:

- Interventions identified in the plan and their effectiveness;
- Attempts made of changing or eliminating maladaptive behaviors and increasing adaptive behaviors;
- Documentation continues to be required each day TBS is delivered;
- Must include a comprehensive summary covering the time TBS services were provided, but need not document every minute of service time; and
- Time (which must be converted to minutes) of service may be noted by contact or by shift.

TBS Progress Note Documentation¹⁸⁸

TBS 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. These

Note: TBS interventions also may include support for the family or foster family/support system's efforts to provide a positive environment for the child/youth and collaboration with other members of the mental health treatment team.¹⁸⁹

Unplanned Services

3.1 Crisis Intervention

Description

Crisis Intervention is a service, lasting less than 24 hours, to or on behalf of a child for a condition that requires more timely response than a regularly scheduled visit. Service activities include, but are not limited to, one or more of the following: assessment, collateral and therapy. Crisis Intervention is distinguished from Crisis Stabilization by being delivered by providers who do not meet the Crisis Stabilization contact, site

and staffing requirements described in subsections 3.2 and 3.3 below.¹⁸⁹

Contact and Site Requirements (Crisis Intervention)¹⁹⁰

Crisis Intervention Services may either be face-to-face or by telephone with the child or the child's Significant Support Person and may be provided anywhere in the community.

Unplanned Services

3.1 Crisis Intervention

Note: The identified “Crisis” must be the child’s crisis, not the significant support person’s crisis. Although a significant support person may be experiencing a personal or financial crisis (example, struggling with his/her own mental health issues, loss of job, housing, etc.) one may not claim Crisis Intervention that is not linked to the client.¹⁹¹

CCR Title 9, Chapter 3, (regarding the administration of Community Mental Health under the Short-Doyle Act), further defines *Crisis Intervention*, as an “immediate therapeutic response which must include a face-to-face contact with a patient exhibiting acute psychiatric symptoms to alleviate problems which, if untreated, present an *imminent threat* to the patient or others.”

“Specialty Mental Health” does permit this service to be provided either face-to-face or by telephone with the child/youth or with the child/youth’s significant support person.¹⁹²

Claiming Unit (Crisis Intervention)

Crisis Intervention shall be based on minutes of staff time. The maximum claimable time for Crisis Intervention in a 24-hour period is eight hours (480 minutes).

Lockouts (Crisis Intervention)¹⁹³

Crisis Intervention is not reimbursable on days when Crisis Residential Treatment Services, Psychiatric Health Facility Services, or Psychiatric Inpatient Services are reimbursed by Medi-Cal except for the day of admission to those services.

Staffing (Crisis Intervention)

Crisis Intervention can be provided by any person determined by the MHP to be qualified to provide the service, consistent with scope of practice and state law.

Unplanned Services

3.2 Crisis Stabilization

Description

“Crisis Stabilization” means a service lasting less than 24 hours, to or on behalf of a child for a condition that requires more timely response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: Crisis Intervention, Medication Support Services, Assessment, Evaluation Collateral, and Therapy. Crisis Stabilization is distinguished

from Crisis Intervention by being delivered by providers who do meet the Crisis Stabilization contact, site, and staffing requirements described in Sections 1840.338 and 1840.348.¹⁹⁴

Note: The maximum allowances established by Title 22, Section 51516, except that the definitions of individual specialty mental health services shall be the definitions in this Chapter. When Crisis Stabilization is claimed under this Subchapter, the maximum allowance provided in Title 22, Section 51516, for “Crisis Stabilization-Emergency Room” shall apply when the service is provided in a 24-hour facility, including a hospital outpatient department. The maximum allowance for “Crisis Stabilization-Urgent Care” shall apply when the service is provided in any other appropriate site.¹⁹⁵



Unplanned Services

3.2 Crisis Stabilization

Contact and Site Requirements (Crisis Stabilization)¹⁹⁶

- a. Crisis Stabilization shall be provided on site at a licensed 24-hour health care facility or hospital based outpatient program or a provider site certified by DMH or an MHP to perform crisis stabilization.
- b. Medical backup services must be available either on site or by written contract or agreement with a general acute care hospital. Medical backup means immediate access within reasonable proximity to health care for medical emergencies. Immediate access and reasonable proximity shall be defined by the Mental Health Plan. Medications must be available on an as needed basis and the staffing pattern must reflect this availability.
- c. All clients 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 client's need shall be made; to the extent resources are available.

Service Activities (Crisis Stabilization)

Crisis Stabilization is provided as a package of service activities including, but not limited to: Crisis Intervention, Assessment, Evaluation, Collateral, Medication Support Services, and Therapy.

All children/youth receiving Crisis Stabilization services shall receive a physical and mental health assessment. If outside services are needed, a referral which corresponds with the child/youth's need shall be made to the extent resources are available.

Claiming Unit (Crisis Stabilization)¹⁹⁷

Crisis Stabilization shall be based on hours of time. Partial blocks of time shall be rounded up or down to the nearest one hour increment except that services provided during the first hour shall always be rounded up. A maximum number of hours claimable in a 24-hour period shall be 20 hours.¹⁹⁸

Lock-outs (Crisis Stabilization)¹⁹⁹

Crisis Stabilization is not reimbursable on days when Psychiatric Inpatient Services or Psychiatric Health Facility Services are reimbursed by Medi-Cal, except for the day of admission. No other Specialty Mental Health Services are reimbursable during the same time period this service is reimbursed.

Staffing (Crisis Stabilization)²⁰⁰

- a. A physician shall be on call at all times for the provision of those Crisis Stabilization Services that may only be provided by a physician.
- b. There shall be a minimum of one Registered Nurse, Psychiatric Technician, or Licensed Vocational Nurse on site at all times beneficiaries are present.
- c. At a minimum there shall be a ratio of at least one licensed mental health or waived/registered professional on site for each four beneficiaries or other patients receiving Crisis Stabilization at any given time.
- d. If the beneficiary is evaluated as needing service activities that can only be provided by a specific type of licensed professional, such persons shall be available.
- e. Other persons may be utilized by the program, according to need.
- f. If Crisis Stabilization services are co-located with other specialty mental health

Unplanned Services

3.2 Crisis Stabilization

services, persons providing Crisis Stabilization must be separate and distinct from persons providing other services.

- g. Persons included in required Crisis Stabilization ratios and minimums may not be counted toward meeting ratios and minimums for other services.

Note: Staff included in required Psychiatric Inpatient, PHF, or Nursing Facility ratios or minimums shall not be counted toward meeting Crisis Stabilization staffing as evidenced by a clear staffing/schedule of assignments as an audit trail.²⁰¹

4. Targeted Case Management (TCM) Services

4.1 Description

“Targeted Case Management” (TCM) means services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary’s progress; placement services; and plan development.²⁰²

4.2 Site and Contact Requirements²⁰³

Targeted Case Management (TCM) may be either face-to-face or by telephone with the child/youth or significant support persons and may be provided anywhere in the community.

4.3 Claiming Units²⁰⁴

The Claiming unit for TCM is staff time, based on minutes of time.

4.4 Lock-outs²⁰⁵

- a. Targeted Case Management Services are not reimbursable on days when the following services are reimbursed, except for day of admission or for placement services as provided in Subsection b.:
 1. Psychiatric Inpatient Hospital Services
 2. Psychiatric Health Facility Services
 3. Psychiatric Nursing Facility Services
- b. Targeted Case Management Services, solely for the purpose of coordinating placement of the beneficiary on discharge from the 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.

4.5 Staffing

TCM Services may be provided by any person determined by the MHP to be qualified to provide the service, consistent with scope of practice and state law.



5. Reimbursement Requirements for EPSDT Specialty Mental Health Services

This chapter outlines EPSDT specialty mental health service rules for reimbursement and identifies those activities that are clearly non-reimburs-

able. Rules regarding whether or not services are reimbursable are determined, to a large extent, how delivery of those services are documented.

Reimbursement Requirements for EPSDT Specialty Mental Health Services

5.1 Reimbursement Rules

An EPSDT service provider must adhere to each of the following reimbursement rules in order to be reimbursed for an EPSDT speciality mental health service and EPSDT supplemental speciality mental health service:

- The EPSDT service provider must be a person or entity that meets the Medical program's standards for participation as established under Titles XVIII and XIX of the Social Security Act;²⁰⁶
- EPSDT providers must obtain payment authorization from the MHP prior to rendering an EPSDT supplemental specialty mental health service, Day Treatment Intensive, and Day Rehabilitation;²⁰⁷
- Contacts with significant support persons in the beneficiary's life are reimbursable only if they are directed exclusively to the mental health needs of the beneficiary;²⁰⁸
- When services are provided to or on behalf of a beneficiary by two or more persons at a single point in time, each person's involvement must be documented in the context of the mental health needs of the beneficiary;²⁰⁹
- Services must be provided within the scope of practice of the person delivering the service, if professional licensure is required for the service. The local MHP is responsible for assuring that the provider

rendering the services meets the Plan's professional licensure and/or certification requirements;²¹⁰ and

- All services must be provided under the direction of either a 1. physician; 2. psychologist; 3. Licensed Clinical Social Worker; 4. Marriage and Family Therapist; 5. Registered Nurse; or 6. waived/registered professional when supervised by a licensed mental health professional in accordance with laws and regulations governing the registration or waiver. For purposes of this requirement, "direction" includes, but is not limited to, acting as a clinical team leader, direct or functional supervision of service delivery, or approval of client plans. An individual does not have to be physically present at the service site to exercise direction.²¹¹

Claiming Requirements for Service Functions Based on Minutes of Time²¹²

For the following EPSDT specialty mental health services, the claiming unit is actual time the provider spends delivering the service, stated in minutes of time:

- Mental Health Services
- Medication Support Services
- Crisis Intervention
- Targeted Case Management

The following requirements apply for claiming of

Reimbursement Requirements for EPSDT Specialty Mental Health Services

5.1 Reimbursement Rules

services based on minutes of time:

- The exact number of minutes used by persons providing a reimbursable service must be reported and claimed. In no case will more than 60 units of time (60 minutes) be reported or claimed for any one person during a one-hour period. In no case will the units (minutes) of time reported or claimed for any one person exceed the amount of actual time worked.
- When a person provides service to, or on behalf of, more than one beneficiary at the same time, the person's time must be prorated to each beneficiary. When more than one person provides a service to more than one beneficiary at the same time, the time spent by all persons providing the service must be added together to yield the total claimable units (minutes) of service.

Example: If a service is provided by two staff/clinicians to a group of seven EPSDT-eligible beneficiaries and the reimbursable service, including direct service, travel time and documentation, lasts one hour and 35 minutes for each person providing the service, total unit (minutes) reported would be 95 minutes (60+35) multiplied by two staff divided by seven beneficiaries $[(95 \text{ minutes} \times \text{two staff}) / 7 \text{ beneficiaries}] = 27.1$ minutes per beneficiary. This would be rounded to the nearest minute, so 27 minutes would be claimed for each beneficiary.

- The time required for documentation and travel is reimbursable only when the documentation or travel is a component of a reimbursable service activity, whether or not the time is on the same day as the reimbursable service activity.
- Plan development for Mental Health Services and Medication Support

Services is reimbursable. Units of time (minutes) spent in plan development activities may be claimed regardless of whether there is a face-to-face or telephone contact with the beneficiary.

Claiming Requirements for Service Functions Based on Half Days or Full Days of Time²¹³

For the following EPSDT specialty mental health services, the claiming unit is a half day or full day of service:

- Day Treatment Intensive
- Day Rehabilitation

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

- A half day must be claimed for each day in which the beneficiary 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.
- A full day must be claimed for each day in which the beneficiary receives face-to-face services in a program with services available more than four hours per day.
- Although the beneficiary must receive face-to-face services on any full day or half day claimed, all service activities during that day are not required to be face-to-face with the beneficiary.
- Beneficiaries must be present for at least 50% of the day program activity.²¹⁴

Claiming Requirements for Service Functions Based on Hours of Time²¹⁵

For the following EPSDT specialty mental health service, the claiming unit is an hour of time:

- Crisis Stabilization

Reimbursement Requirements for EPSDT Specialty Mental Health Services

5.1 Reimbursement Rules

The following requirements apply for claiming of services based on hours of time.

- Each one-hour block of time that the beneficiary receives crisis stabilization services must be claimed.
- Partial blocks of time must be rounded up or down to the nearest one-hour

increment, except that services provided during the first hour must always be rounded up.

Note: Costs for documentation are included in the rates for this service and cannot be claimed separately.

Reimbursement Requirements for EPSDT Specialty Mental Health Services

5.2 Non-Reimbursable Services/Activities

This Chapter describes those services or activities that are clearly non-reimbursable as EPSDT specialty mental health services since they are not eligible for Federal Financial Participation (FFP).²¹⁶

5.2.1 Services that Are Not Allowable²¹⁷

- No service provided: Missed appointment²¹⁸
- Academic educational services
- Vocational services that have as a purpose actual work or work training
- Recreation
- Services provided were solely clerical²¹⁹
- Supervision of all staff (including clinical internship, clinical hours, discipline, etc.)
- Service provided solely payee related²²⁰
- Personal care services provided to beneficiaries. These include grooming, personal hygiene, assisting with medication, and meal preparation when performed for the child²²¹
- Socialization, if it consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors of the beneficiaries involved
- Medi-Cal program benefits that are excluded from coverage by the local mental health plan²²²
- Specialty Mental Health Services that are Minor Consent Services, if they are provided to a child whose eligibility is limited to Minor Consent Services²²³
- Solely transportation of an individual to or from a service²²⁴
- Translation or interpretive services including sign language
- Services provided to beneficiaries residing in institutional settings such as juvenile hall, Institution for Mental Disease [IMD]
- Report writing (such as a child abuse report)
- Services provided while child or youth is in a hospital mental health unit, psychiatric health facility, nursing facility, or crisis residential facility²²⁵
- In TBS:
 - a. For the convenience of the family, caregivers, physician, or teacher
 - b. To provide supervision or to ensure compliance with terms and conditions of probation
 - c. To ensure the child/youth's physical safety of the safety of others, e.g., suicide watch
 - d. To address conditions that are not a part of the child/youth's mental health condition²²⁶

Reimbursement Requirements for EPSDT Specialty Mental Health Services

5.3 Factors to Consider

Certain factors should be considered in determining whether a service is reimbursable. These factors include the purpose of the service and the site where the service is provided. A service is reimbursable only if its purpose is to assist the child in integrating into the community, accessing needed resources, and maximizing interpersonal skills. Activities or interventions whose purpose is solely to provide vocational training, academic education or recreational activity are not reimbursable.

Reimbursable services may be delivered anywhere in the community (if not a lock-out, such as correctional institutions, inpatient psychiatric hospitals, crisis residential, etc.). This includes, but is not limited to a work, academic, or recreational site, in the home or in the community. However, to be reimbursable, the service intervention must focus on helping the child to meet the goals and objectives identified in the client plan, including, but not limited to; integrating into the community, accessing needed resources, or maximizing personal skills.

5.3.1 Situational Examples

The following examples are intended to assist EPSDT providers in determining whether services related to academic, vocational, or recreational activities are reimbursable as an EPSDT supplemental specialty mental health service. Such services may be reimbursable in some situations but not in others.

Note: All of the following examples provided must be specifically tied to the child/youth's diagnosis and matched to clear and measurable goals in the Client Plan to be considered claimable activities. The intervention/technique (i.e., modeling, coaching, cognitive-behavioral therapeutic action, redirecting) must be clearly documented.

Academic Situations

- Accompanying a youth in a community college class due to the youth's overwhelming fear and anxiety and reviewing stress reducing skills during the class and debriefing the experience afterwards **is** reimbursable.
- Assisting the child with homework (such as quizzing, testing, monitoring, researching a topic, etc.) **is not** reimbursable.
- Assisting a transitioned aged youth with arithmetic so he/she can manage the household budget which is an independent living skill (building independent functioning skills) so he/she can do it themselves **is** reimbursable.
- In a Day Treatment setting, teaching a class in remedial English **is not** reimbursable.
- Assisting a child on focusing his/her attention on how to create a less distracting and anxiety provoking environment to complete his/her homework **is** reimbursable.

Vocational Situations

- Assisting the youth in considering how his/her supervisor's criticism affects him/her and strategies for handling the situation **is** reimbursable, regardless of where the service is delivered.
- Visiting a youth's job site to provide instruction on how to flip hamburgers **is not** reimbursable.
- Responding to an employer's call for assistance when the youth is in tears at work because he or she is having difficulty learning how to operate a new piece of equipment **is** reimbursable if the focus of the intervention is on assisting the youth to become less anxious so

Reimbursement Requirements for EPSDT Specialty Mental Health Services

5.3 Factors to Consider

- that he/she can concentrate on learning the new skill.
 - Providing hands-on technical assistance to the youth regarding the new piece of equipment **is not** reimbursable.
 - Teaching typing to a group of youths publishing a Day Treatment newsletter **is not** reimbursable.
 - In a Day Treatment setting, assisting youths who are publishing a newsletter how to prioritize and organize tasks more effectively to decrease their frustration and increase their organizational and coping skills **is** reimbursable.
- Recreational Situation**
- Teaching a youth how to lift weights so he/she does not sustain an injury **is not** reimbursable.
 - Role playing with a youth how to take turns, interact as a team player and resolve conflicts without aggression **is** reimbursable.
 - Attending a group outing and watching a movie with no documentation of mental health intervention or plan for skill building **is not** reimbursable.
 - Attending an outing and individualizing the experience that centers on the client's identified symptom or behavior that meets medical necessity. (Example; assisting the child, whose diagnosis is Attention Deficit Disorder and is easily distractible, how to stay focused or how to select activities that help them stay focused **is** reimbursable).

Documentation of Services

6.1 Overview

The clear, concise and succinct documentation of services rendered is critical in the substantiation of these services. The following best practice guidelines provide a general guide regarding the documentation of services. EPSDT Providers should seek guidance from their MHP for further guidance on this topic.

6.1.1 General Documentation Standards²²⁷

- The date of service is included in all services documented.²²⁸
- Charting must be legible, including the legibility of provider's signature. Illegibility and absence of signature can be a reason for recoupment.²²⁹
- Each contact note with the child/youth or significant support person includes a clinical decision and intervention that is directed exclusively to the mental health needs of the child/youth.²³⁰
- A signature (or electronic equivalent) of the staff providing the service includes the clinical license, professional degree, or job title (if staff member is licensed, clinical license, such as LCSW, MD, MFT, etc., must be included).²³¹
- *Timeliness/frequency:*²³² Records should include a corresponding note for services provided according to the following types of services indicated below:
 1. **Every service contact for:**
 - A. Mental Health Services
 - B. Medication Support Service
 - C. Crisis Intervention

Documentation of Services

6.1 Overview

- D. Targeted Case Management (daily or weekly summary)

2. Daily for:

- A. Crisis residential
- B. Crisis stabilization (one per 23-hour period)
- C. Day treatment intensive

3. Weekly for:

- A. Day Treatment Intensive summary which is signed or co-signed by one of the following:
 - Physician
 - Licensed/registered/waivered Psychologist
 - Licensed Clinical Social Worker (LCSW) or related registered professionals (ASW)
 - Marriage and Family Therapist (MFT) or related registered pro-

fessionals (MFT-Intern [IMF])

- Registered Nurse (RN)

- B. Day Rehabilitation

4. Every service contact:

Therapeutic Behavioral Services require a progress note for each time period that a mental health provider spends with the child/youth.²³³

5. As determined by the MHP:

The above Timeliness and Frequency standards are a minimum set criteria established by DMH. The MHP retains the authority to set additional higher or more specific standards for documentation timeliness and frequency for any services, provided that standard is consistent with applicable state and federal laws and regulations.

Documentation of Services

6.2 Medical Necessity²³⁴

Medical Necessity is required for Claiming EPSDT Medi-Cal.

Medical Necessity is determined by the following factors:

1. The child/youth has an included DSM IV-TR/ICD-9 diagnosis.²³⁷ (See Appendix 2 for “included” diagnosis list)
2. As a result of the included diagnosis, the child/youth must have, at least, one of the following criteria:
 - a. A significant impairment in an important area of life functioning.
 - b. A probability of significant deterioration in an important area of life functioning.

- c. A probability that the child will not progress developmentally as individually appropriate.

3. Additionally, the child/youth must meet both of the following intervention criteria:

- a. Focus of proposed intervention is to address the condition identified (Referenced above)

- b. The proposed intervention will do, at least, one of the following:

- i. Significantly diminish the impairment;
- ii. Prevent significant deterioration in an important area of life functioning; or

Documentation of Services

6.2 Medical Necessity²³⁵

- iii. Allow the child to progress developmentally as individually appropriate.
4. If the client is under 21 years of age and does not meet the above Medical

Necessity criteria, the client is eligible under EPSDT²³⁷ when specialty mental health services are needed to correct or ameliorate a defect, mental illness, or condition.²³⁸

Documentation of Services

6.3 Assessment²³⁸

Assessment(s), evaluation(s), and/or other documentation support Medical Necessity and documents support for the DSM IV-TR diagnosis that substantiates Medical Necessity. The plan of care is driven by the assessment. The assessment information need not be in a specific document or section of the chart, but should be clearly evident and identifiable.

6.3.1 Assessment Criteria

The following areas shall be included in the Assessment, as appropriate, as a part of a comprehensive client record:²³⁹

1. Relevant physical health conditions reported by the child/youth or caregiver shall be prominently identified and updated as appropriate;
2. Presenting problems and relevant conditions affecting the child's physical health and mental health status (example: living situation, daily activities, and social support, et cetera);
3. Child's strengths in achieving identified client plan goals;
4. Special status situations that present a risk to the child or others shall be prominently documented and updated as appropriate;
5. Medications that have been prescribed by the Mental Health Plan physicians, including dosages of each medication, dates of initial prescriptions and refills, and documentation of informed consent for medications;
6. Child/youth or caregiver report of allergies and adverse reactions to medications, or lack of known allergies/sensitivities shall be clearly documented;
7. A mental health history that includes: previous treatment dates, providers, therapeutic interventions and responses, sources of clinical data, relevant family information and relevant results of relevant lab tests and consultation reports;
8. Pre-natal and perinatal events and complete developmental history;
9. Past and present use of tobacco, alcohol, and caffeine, as well as illicit, prescribed and over-the-counter drugs;
10. A relevant mental status examination; and
11. A five axis diagnosis from the most current DSM, or a diagnosis from the most current ICD, shall be documented, consistent with the presenting problems, history, mental status evaluation and/or other assessment data.

Documentation of Services

6.3 Assessment²³⁸

6.3.2 Assessment Frequency and Timeliness

1. The local MHP establishes standards for timeliness and frequency for Assessments.²⁴⁰
2. If not an urgent, crisis, or emergency situation, the MHP should only claim those assessment services necessary to establish medical necessity.²⁴¹
3. It is understood that MHPs have established 30-90 day intake periods (or longer, if need is documented) during which time the provider is to establish Medical Necessity, set up the client plan, and coordinate the arrangement of necessary services. However, the intake period is not exempt from the Medical Necessity requirements for claiming Medi-Cal.²⁴²

Documentation of Services

6.4 Client Plan²⁴³

Client Plans drive services. Client Plans are to be based on the Assessment and shall include the following elements:²⁴⁴

- Specific, observable, or quantifiable goals tied to the presenting behaviors and DSM IV-TR diagnosis determined in the Assessment are consistent with the diagnoses.²⁴⁵
- The types and focus of interventions will be consistent with the client plan goals.²⁴⁶
- Duration of the interventions.²⁴⁷
- Proposed intervention will significantly diminish the impairment, prevent significant deterioration in an important area of life functioning or will allow the child/youth to progress developmentally as individually appropriate.²⁴⁸
- When Day Treatment (Day Treatment Intensive or Day Rehabilitation) is included in the client plan, the client plan *must* identify the goal(s) that Day Treatment will assist the child/youth achieve and the proposed duration of the Day Treatment Program.²⁴⁹ This is true for all children including those children/youth in group home programs.
- Signature (or electronic equivalent) of, at least, one of the following:²⁵⁰
 - A person providing the service(s).
 - A person representing the MHP providing the service.
- If the above person providing the service is not licensed or waived/registered, a co-signature from a physician, licensed or waived/registered psychologist, licensed or registered social worker, licensed or registered marriage and family therapist, or a registered nurse is required.²⁵¹
- Evidence of the child/youth's degree of participation and agreement with the client plan as evidenced by the child/youth or legal guardian's signature. If child/youth or legal guardian is unavailable or refuses to sign the client plan, a written explanation in the progress notes why the signature could not be obtained ²⁵² and best practice would include evidence of follow-up efforts to obtain the signature of the child/youth

Documentation of Services

6.4 Client Plan²⁴³

or legal guardian are documented in the progress notes. Client participation in the formulation of the plan is a crucial factor in service delivery and in gaining cooperation for a positive outcome of the proposed interventions. Follow-up efforts to obtain a signature and evidence of client's participation should be documented if the client is initially "unavailable to sign."

- Best practice would include consideration of culturally competent demographic variables (i.e. culture, socio-economic, gender, environment).
- Evidence that a copy of the Client Plan

will be provided to the client upon request.²⁵³

6.4.1 Client Plan Frequency and Timeliness

1. Client Plans should be initially completed within the time period specified in MHP's documentation guidelines. If not dictated in the MHP guidelines, the Client Plan is to be completed within 60 days of the intake unless there is documentation supporting the need for more time.²⁵⁴
2. Client Plans should be updated at least annually as specified in MHP's documentation guidelines.²⁵⁵

Documentation of Services

6.5 Progress Notes - Planned Services

The following factors should be considered in all Planned Service notes as best practice and may be amended or further defined by the Mental Health Plan.

Progress Notes for Planned Services need to focus on the service provided to the client as a component of the Client Plan.

- Clearly identify the writer, the client and other persons involved as well as the relation to the client or involvement in the case, except where rules for confidentiality would prevent clearly identifying someone in a progress note.
- Clearly identify the location of the service activity.
- When providing a Planned Service, go in with a plan or objective; this will lend it self to document an outcome of your

plan or objective.

- Avoid "observational" or "narrative" (i.e., purely descriptive) notes that detail what was observed but provide no intervention or redirection or action taken.
- Summarize and be succinct; only include details as needed and necessary to convey the goal, the intervention, the client or collaterals response and the follow-up plan (referred to as a note "standing on its own").
- Use a standard of documentation that addresses the clinically relevant service provided as it relates to the treatment goals and objectives of the child/youth and the Client Plan. This standard may include, but is not limited to identifying the child/youth's presenting maladaptive behavior or symptom, addressing the assessment or intervention provided

Documentation of Services

6.5 Progress Notes - Planned Services

or utilized by staff, recording the child/youth's response to the intervention, redirection, action, etc., and next step measures or plans to reassess, continue with existing client plan or introduce new interventions to eliminate maladaptive behaviors and/or symptoms and introduce or reinforce constructive replacement behaviors and reduction

of presenting problem behaviors and/or symptoms.

- When documenting/writing clinical reports or communiqué claimed under EPSDT, always include a copy of the clinical report/communiqué in the chart as substantiation or evidence of the task claimed.

Documentation of Services

6.6 Progress Notes - Unplanned Services

The following factors should be considered in all Unplanned Service notes as best practice and may be amended or further defined by the Mental Health Plan.

Unplanned Service notes such as Crisis Intervention and Crisis Stabilization should always include all of the above Planned note elements, but also should include the following additional elements:

- Relevant clinical details including precursors and events leading to the unplanned service; the urgency and immediacy of the situation should clearly document either:
 1. How the “Emergency Psychiatric Condition” meets the criteria for Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient Hospital Services (CCR, Title 9, §1820.205), due to a mental disorder, and the child or youth is *imminently* a current danger to self

or others, or unable to provide for or utilize, food, shelter or clothing (secondary to a mental disorder), and requires psychiatric inpatient hospital or psychiatric health facility services, if applicable;²⁵⁶ or

2. Reflects an “Urgent Condition” experienced by the child/youth that, without timely intervention, is highly likely to result in an immediate emergency psychiatric condition;²⁵⁷
- Immediate assessment of risk with appropriate interventions to decrease risk and address child/youth's safety and well-being;
 - Measures taken to decrease or eliminate or alleviate danger, reduce trauma and/or ameliorate the Crisis;
 - Involvement of child/youth in his/her own aftercare safety plan; and
 - Clearly document collateral and community contacts that will participate in follow-up discharge plan and aftercare issues.

Documentation of Services

6.7 Progress Notes - Targeted Case Management Services

“Targeted Case Management” (TCM) means services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and re-

ferral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary’s progress; placement services; and plan development. TCM Progress Notes should reflect the Medical Necessity for the above service activities.

Documentation of Services

6.8 Progress Notes - Case Management Services

Case Management notes generally reflect planning, linking and coordinating with others generally reflect planning, linking and coordinating with others on behalf of the child/youth. Best practice recommends notes that reflect what was

discussed, what is the plan and what “next step actions” specific are needed to assist the client in linking to an activity or a service that will benefit the child/youth.

Documentation of Services

6.9 Charts/Individual Records

The documentation of services needs to be clear as to what are the essential elements that need to be documented consistent with regulations, by MHP contract, by Medi-Cal and by good clinical practice.

Although there is no set “standard” for how charts and individual records are to be assembled or kept, the following are general procedures that may assist providers in their charting practices.

6.9.1 Record Content

The following procedures are consistent with good clinical practice:

- Records should succinctly and legibly document all care provided to the child/youth;
- Records should include the child/youth’s

name with a unique, assigned Medical Record number that associates that particular record with a specific client and will aid in filing the correct record with the correct client;

- Records should be sequential and date ordered;
- Records should be completed within a standard of “reasonable” timeliness as directed by the MHP;²⁵⁸
- When making a late Progress Note entry in a chart, good clinical practice recommends that the author documents the actual date the service was provided (for that date) and also includes the date the late entry was actually documented next to the author’s signature;
- Record content should be specific to the

Documentation of Services

6.9 Charts/Individual Records

- individual and not contain records pertaining to another child or individual;
- Records should be aggregated and divided into sections according to a standard allowing for ease of location and referencing;
- Records should be attached or fastened together to avoid loss or being misplaced;
- Records should substantiate all services provided and support all claimed claims;
- Travel and documentation time must be linked to the service provided and recorded in the progress note as part of the claim of the service provided;²⁵⁹
- Errors and corrections should be indicated with a single line crossing out the error, initialed by the person making the correction and the date correction was made;
- 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;²⁶⁰ and
- When considering whether or not to have an “all inclusive” record versus a segregated record (example: inclusion of a mental health service record in school-based charts), one must assess the risks and benefits on a “role-based” need-to-know continuum. DMH does allow records to be aggregated into a single chart when provided by a single provider entity with different cost centers/reporting units provided the chart clearly delineates the different cost centers/re-

porting units in separate sections. One should note, however, that confidentiality laws and regulations may vary according to the service provided and play in the decision of “all inclusive” versus “segregated” individual records.

Example: If Provider “A” has a program for outpatient mental health services, a Day Rehab program and also provides psychological testing services that are co-located at the same site, Provider “A” may choose to have one-single chart with three distinct sections for each of these programs. Provider “B” also has a program for outpatient mental health services, Day Rehab program and also provides psychological testing services, however, these services are located at three different sites miles from each other; Provider “B” may choose to have three-separate charts (that can stand alone on their own merit) due to the logistics of the services provided.

6.9.2 Record Storage

The following procedures are consistent with good clinical practice:

- A child/youth medical record contains Protected Health Information (PHI) covered by both state and federal confidentiality laws.²⁶¹ Additionally, the accessibility, integrity, safety, storage, and maintenance of these records are covered by Health and Safety Code,²⁶² Civil Code,²⁶³ under Title 22, Licensing and Certification, Division 5 and the Healthcare Insurance Portability and Accountability Act (HIPAA).²⁶⁴
- Providers are to safeguard the information in the record against loss, defacement, tampering or use by unauthorized persons.

The means by which to store medical records

Documentation of Services

6.9 Charts/Individual Records

typically include consideration to the following good clinical practices:

- A controlled chart check-out or retrieval system for access, accountability and tracking.
- Secure filing system (both physical plant and electronic safeguards used when applicable).
- Safe and confidential retrieval system for charts that may be stored off-site or archived.

Risk determinations and oversight of record storage should be conducted locally and in consultation with designated MHP Quality Management site certification personnel for direction and instructions specific to the organization and as dictated by the MHP.

6.9.3 Record Retention

The client's records are to be preserved for a mini-

imum of seven years following discharge of the client, except the records of an unemancipated minor shall be kept at least one year after such minor has reached the age of 18 years and, in any case, not less than seven years.²⁶⁵ For Psychologists, client records are to be maintained for seven years from the patient's discharge date, or in the case of a minor, seven years after the minor reaches 18 years of age.²⁶⁶

In the event a provider goes out of business or no longer provides mental health services for which EPSDT is claimed, the provider is still obligated to make arrangements that will assure the accessibility, confidentiality, maintenance, and preservation of this record for the minimum retention time as described above.²⁶⁷

6.9.4 Record Destruction

Client records are to be maintained and destroyed to preserve and assure client confidentiality.²⁶⁸

Documentation of Services

6.10 Discharge Summary²⁶⁹

Discharge summaries document the termination and/or transition of services and provide closure for a service episode and referrals as appropriate.²⁷⁰

Good clinical practice may include the following details in the Discharge Summary:

- Inclusion of an aftercare plan provided to the caregiver and child/youth that include recommendations regarding follow-up treatment plans which are relevant to the child's continuing care that is written so as to be easily understood by a layperson;
- Community referrals and support systems provided
- Medications prescribed including side effects or sensitivities and dosage schedules;
- Essential information relative to the child's mental health diagnosis, intervention course, rehabilitation potential;
- Expected course of recovery;
- Performance Outcome measures as required; and
- Other relevant information.

Documentation of Services

6.10 Discharge Summary²⁶⁹

6.10.1 Discharge Summary claims

Discharge summaries can be claimed under EPSDT if the Discharge Summary meets the EPSDT documentation requirements for service claims. The following points may apply to Discharge Summary claims as best practice:

- Client is open to the cost center or reporting unit;
- The discharge summary includes a clinical decision or intervention (i.e., evidence of a referral for aftercare services, support systems in the community and continued treatment planning recommendation relevant to the client plan goals); and

Discharge summaries may not claim for administrative tasks such as “closing out the chart,” “copying,” and/or “filing.” As a matter of good clinical practice, evidence of an action, referral, or recommendation taken that benefits the child/youth at the conclusion of services, supports the documented service. Mental Health Plans have the authority to dictate how discharges are to be claimed and documented. It recognized that some clients may abruptly discontinue service. A closing comment regarding the reason for case closure is recommended and may account for brevity or incomplete service documentation (when appropriate).

7. Staffing Qualifications for Service Delivery and Documentation

Staff Qualifications are dictated in general by the following standards and scope of practice as de-

finied by California Code of Regulations, Title 9, and the MHP.

Staffing Qualifications for Service Delivery and Documentation

7.1 LPHA²⁷¹

A “Licensed Practitioner of the Healing Arts” possesses a valid California clinical licensure in one of the following professional categories:

1. Physician²⁷²
2. Licensed Clinical Psychologist²⁷³
3. Licensed Clinical Social Worker²⁷⁴
4. Licensed Marriage and Family Therapist²⁷⁵
5. Registered Nurse²⁷⁶

Approved Activities:

- Can function as a “Head of Service” on agency application;

- Can authorize services as directed by the MHP;
- Can conduct comprehensive assessments and provide a diagnosis without co-signature (except for RN staff which is not within scope unless a Nurse Practitioner; check with local MHP);
- Can co-sign the work of other staff members within their scope of practice; and
- Can claim for all services categories within their scope of practice (example,

Staffing Qualifications for Service Delivery and Documentation

7.1 LPHA²⁷¹

a psychiatrist and registered nurse can claim for Medication Support Services,

however, psychologists, LCSWs, and MFTs cannot).

Staffing Qualifications for Service Delivery and Documentation

7.2 LPHA Licensed Waivered/Registered Professional²⁷⁷

A “licensed waivered staff” member includes the following:

7.2.1 Registered Psychologists/ Psychological Assistants²⁷⁸

Psychologist interns are individuals registered with the Board of Psychology as a “Registered Psychologists” or “Registered Psychological Assistants” that possess and earned doctorate degree in psychology or educational psychology, or in education with the field of specialization in counseling psychology or educational psychology in order to obtain supervised post-doctoral clinical hours towards licensure as a psychologist. The waiver for Registered Psychologists/Psychological Assistants is issued by DMH and is granted up to five years from the initial date of registration with the Department.²⁷⁹ The waiver allows the Registered Psychologist/Psychological Assistant to function as an LPHA while acquiring experience towards clinical licensure.

7.2.2 Registered Marriage Family Therapist Interns/Associate Social Workers

Registered Marriage and Family Therapist Interns (MFT-Interns) and Associate Social Workers (ASW) are individuals registered with the Board of Behavioral Sciences in order to obtain supervised clinical hours and acquiring clinical experience towards licensure as a Marriage Family Therapist and Licensed Clinical Social Worker, respectively. The oversight for Registered Marriage Family Therapist-Interns and Associate So-

cial Workers is monitored by the MHP.²⁸⁰

Note: Registered Psychologist/Psychological Assistants are granted waiver by DMH and Registered Marriage Family Therapist Interns/Associate Social Workers are oversighted and monitored by the MHP.

Approved Activities

Registered Psychologist/Psychological Assistants, Registered Marriage Family Therapist Interns/Associate Social Workers may perform the following activities under the supervision of a licensed professional within their scope of practice:

- Can function as a LPHA staff for the time dictated by the MHP and DMH;
- Cannot function as the Head of Service unless they meet qualifications dictated by the California Code of Regulations;²⁸¹
- Can authorize services as directed by the MHP;
- Can conduct comprehensive assessments and provide a diagnosis without co-signature while under waiver;
- Can co-sign the work of other staff members within their scope of practice other than another graduate students performing therapy;
- Can claim for all Mental Health Services, Unplanned Services, and Targeted Case Management within their scope of practice; and

Staffing Qualifications for Service Delivery and Documentation

7.2 LPHA Licensed Waivered/Registered Professional²⁷⁷

- Cannot hold themselves out as independent practitioners and claim as an Enrolled Network Provider.²⁸²

Staffing Qualifications for Service Delivery and Documentation

7.3 Graduate Student

A “Graduate Student” is an individual participating in a field intern/trainee placement while enrolled in an accredited Masters in Social Work (MSW), Masters of Art (MA)/Masters of Science (MS), or clinical/educational psychology doctorate degree program that will prepare the student for licensure within his/her professional field.²⁸³

There is no minimum experience required for graduate students. Some Graduate Students may qualify as “Mental Health Rehabilitation Specialists” if employed by the Provider, if their experience permits, and the MHP allows for this designation.

Approved Activities

Graduate Students may perform the following activities under the supervision of a licensed or waived professional within their scope of practice:

- Can conduct comprehensive assessments and client plans, but require a co-signature by a licensed LPHA;²⁸⁴
- Can write progress notes but require a co-signature by a licensed LPHA;
- Can claim for individual and group therapy but require oversight and co-signature of a licensed LPHA staff member; and
- Can claim for any service within the scope of practice of the discipline of his/her graduate program.

Note: Waivered/Registered Professional staff cannot co-sign for a graduate student’s therapy work.²⁸⁵ Therapy work must be co-signed by a licensed professional within their scope of practice.

Staffing Qualifications for Service Delivery and Documentation

7.4 MHRS²⁸⁶

A “Mental Health Rehabilitation Specialist” is an individual who meets one of the following requirements:

- A mental health rehabilitation specialist shall be 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’

Staffing Qualifications for Service Delivery and Documentation

7.4 MHRS²⁸⁶

experience in a mental health setting.

Approved Activities

MHRS staff may perform the following activities:

- Can function as a “Head of Service” on agency/provider application as determined by the MHP (note: does not qualify as “Director of Local Mental Health Services” unless approved by DMH);²⁸⁷
- Can provide and collect information for assessments;
- The MHP may allow MHRS to co-sign the work of other staff members within the staff member’s scope; and
- Can claim for all Mental Health Services (except Therapy), Unplanned Services, and Targeted Case Management within their scope of practice.

Staffing Qualifications for Service Delivery and Documentation

7.5 Adjunct Mental Health Staff and Other Staff Not Meeting Above Categories²⁸⁸

The MHP has the prerogative and program flexibility to integrate and define other staff (who can provide direct or supportive specialty mental health services) as determined by the MHP administration and approved by DMH.²⁸⁹ It should be noted that it is not a requirement that staff are paid for services provided and claimed to Medi-Cal (i.e., staff may include unpaid graduate students/trainees/interns, volunteers or advocates) as long these unpaid persons meet Medical rules and regulations regarding claiming and scope of practice.

Approved Activities

Adjunct mental health staff and other staff not meeting the above category qualifications may provide services, with evidence of on-going supervision, within the scope of the staff member’s ability, as directed by the MHP.

Note: Mental Health Services, Day Rehabilitation Services, Day Treatment Intensive Services, Crisis Intervention Services, Targeted Case Management, and Adult Residential Treatment Services may be provided by any person determined by the MHP to be qualified to provide the service, consistent with state law and their scope of practice.²⁹⁰



Appendix 1

Sample Progress Notes

Collateral

Returned call to caregiver. Talked to mother regarding a recent incident at the school for which client was suspended. She is very concerned about his behavior and the impact on the younger children in the home. Discussed safety issues in the home and reminded her of interventions practiced in sessions to help de-escalate client's aggressive behavior.

Plan: Will meet at our regular time next week.

-Juan Perez, MFT

Assessment

Met with client and caregiver for first appointment. Caregiver is monolingual Hmong speaking, writer is bi-lingual. Client is a 13-year-old Hmong male who was referred due to truancy and aggressive behavior at school. He is also failing several courses. He is the youngest of four children. Father is deceased. Client denies any gang affiliation but mother is still concerned about his peers. Explained how services will be provided, problem resolution, confidentiality, etc.

Plan: Continue to assess and develop a plan with the client and mom.

-Mai Vang, MFT

Individual Therapy

Met with client for individual session. Discussed progress toward treatment goals. She is still concerned about her reactions in social settings but states that she is less depressed and anxious and may start taking a dance class after school. Client shared journal entries relating to abuse she suffered three years ago. Explored feelings and thoughts triggered by those memories. Role-played coping skills to contain anxiety about peer pressure at school. Encouraged client to continue practicing coping skills and praised her for continuing to use her feelings journal.

-Hong Li, MFT

Group Session

$(2 \times 60) + 0 + 0 + (10 \times 6) / 6 = 30$

This writer co-facilitated a mixed gender social skills group emphasizing peer relationships. Client participated in today's group activity which involved role playing with peers in various social situations. She stated that she enjoyed the activity and stated that it actually helped to alleviate some of her anxiety in dealing with social situations. Writer and the co-facilitator split the group into male and female and role played several examples within the groups and then

brought them back together for discussion and more role playing.

-Juliana Garza, MFT

Rehabilitation

Worked with client on hygiene skills which are impacted by his depression and social isolation behaviors. He has not taken a shower this week. Created a chart with him to help keep track of his ADLs and his feelings so that he can see how they impact one another. He was willing to do this activity. Client was talkative and maintained eye contact during the session. He responded well to praise and seemed hopeful at the end of the session.

Plan: Monitor progress with chart at the next session.

-Cindy Lu, MHAI

Plan Development

Met with client and caregiver to develop a treatment plan that will help the client reduce aggressive, acting out behaviors, which include self harm and cruelty to animals. Discussed goals and objectives with them. Received input from both of them. Also developed a safety plan with crisis numbers and alternative behaviors to practice when client begins to be agitated. Plan to provide individual and family therapy weekly.

-Miriam Smith, LCSW

Case Management

Spoke with CPS Social Worker regarding the foster parents concern with client's increasingly violent behaviors and their inability to keep her in their home since they also have three other foster children. CPS worker will discuss options with the foster family at her next visit. Worker asked that this writer continue to meet with the client weekly to monitor behaviors. Will continue to provide case management with client and include caregivers as appropriate.

-Amar Sarat, MHRS

Crisis Intervention

Mother phoned and client can be heard screaming profanity in the background. Mother is afraid for the safety of others in the home. Client is threatening bodily harm to mother and a younger sibling. Mother asked for help in dealing with this situation. Worker will go out to the home to intervene. Gave mom worker's mobile phone number. Recommended calling the police immediately or taking client to MERT for an evaluation if she feels safe in transporting the client. Client refused to speak to this writer.

-Yoshiko Sumi, MFT

Appendix 2

EPSDT “Included ICD-9 Diagnosis” List

In determining whether a service is covered under this contract based on the diagnosis of the beneficiary, the Contractor shall not exclude a beneficiary solely on the grounds that the provider making the diagnosis has used the International Classification of Diseases (ICD) diagnosis system rather than the system contained in the Diagnostic and

Statistical Manual (DSM) of the American Psychiatric Association. For services provided pursuant to Section C, the Contractor shall consider the following ICD-9 diagnoses codes as included. For any other service, the Contractor may consider these codes as included or may require the provider to use DSM IV.

Included ICD-9 Diagnoses - All Places of Services Except Hospital Inpatient ²⁹¹		
295.00 - 298.9	302.8 - 302.9	311 - 313.82
299.1 - 300.89	307.1	313.89 - 314.9
301.0 - 301.6	307.3	332.1 - 333.99*
301.8 - 301.9	307.5 - 307.89	787.6
302.1 - 302.6	308.0 - 309.9	

*Note: Treatment of diagnoses 332.1 - 333.99, Medication Induced Movement Disorders, is a covered service only when the Medication Induced Movement Disorder is related to one or more included diagnoses.²⁹²

Note: Primary/Principal Diagnosis must be a diagnosis that meets “Medical Necessity” for EPSDT reimbursement. However, other diagnoses that do not meet Medical Necessity (such as substance abuse) may be addressed as a secondary diagnosis.

Appendix 3

Reasons for Recoupment²⁹³

Item No.	Recoupment Reason	Related to:
1	Documentation in the chart does not establish that the child/youth has a diagnosis contained in Section 1830.205(b)(1)(A-R) ²⁹⁴ (See Appendix 2 for Included Diagnosis List)	Medical Necessity
2	Documentation in the chart does not establish that, as a result of a mental disorder listed in Section 1830.205(b)(1)(A-R), the child/youth has, at least, one of the following impairments: <ul style="list-style-type: none"> • A significant impairment in an important area of life functioning; • A probability of significant deterioration in an important area of life functioning; • A probability the child will not progress developmentally as individually appropriate; or • For full-scope Medi-Cal (MC) beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate.²⁹⁵ 	Medical Necessity

Appendix 3

Reasons for Recoupment²⁹³

Item No.	Recoupment Reason	Related to:
3	Documentation in the chart does not establish that the focus of the proposed intervention is to address the condition identified in Section 1830.205(b)(2)(A-C), the child/youth has, at least, one of the following impairments: <ul style="list-style-type: none"> • A significant impairment in an important area of life functioning; • A probability of significant deterioration in an important area of life functioning; or • For full-scope Medi-Cal (MC) beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate.²⁹⁶ 	Medical Necessity
4	Documentation in the chart does not establish the expectation that the proposed intervention will do, at least, one of the following: <ul style="list-style-type: none"> • Significantly diminish the impairment; • Prevent significant deterioration in an important area of life functioning; • Allow the child to progress developmentally as individually appropriate; or • For full-scope Medi-Cal (MC) beneficiaries under the age of 21 years, correct or ameliorate the condition.²⁹⁷ 	Medical Necessity
5	Initial plan was not completed within time period specified in MHP's documentation guidelines, or, lacking MHP guidelines, within 60 days of intake unless there is documentation supporting the need for more time.	Client Plan
6	Client plan was not completed, at least, on an annual basis as specified in MHP's documentation guidelines. ²⁹⁸	Client Plan
7	No documentation of client or legal guardian participation in the plan or written explanation of the client's refusal or unavailability to sign as required in the MHP Contract with the DMH. ²⁹⁹	Client Plan
8	For beneficiaries receiving TBS, no documentation of a plan for TBS. ³⁰⁰	Client Plan
9	No progress note was found for service claimed. ³⁰¹	Progress Notes
10	The time claimed was greater than the time documented. ³⁰²	Progress Notes
11	The progress note indicates that the service was provided while the child/youth resided in a setting where the child/youth was ineligible for Federal Financial Participation (FFP), e.g. Institute for Mental Disease (IMD), jail, and other similar settings, or in a setting subject to lock-outs per Title 9, Chapter 11. ³⁰³	Progress Notes

Appendix 3

Reasons for Recoupment²⁹³

Item No.	Recoupment Reason	Related to:
12	The progress note clearly indicates that the service was provided to a child/youth in juvenile hall and when ineligible for Medi-Cal. (Note: Dependent minor is Medi-Cal Eligible. Delinquent minor is only Medi-Cal eligible after adjudication for release into the community; including a group home or residential treatment facility, evidence substantiating that the court has ordered placement [post-adjudication for placement] in a group home or other setting other than a correctional institution, jail, or other similar settings in the chart necessary.) ³⁰⁴	Progress Notes
13	The progress note indicates that the service provided was solely for one of the following: ³⁰⁵ a. Academic educational service; b. Vocational service that has work or work training as its actual purpose; c. Recreation; or d. Socialization that consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors.	Progress Notes
14	The claim for a group activity was not properly apportioned to all clients present. ³⁰⁶	Progress Notes
15	The progress note does not contain the signature (or electronic equivalent) of the person providing the service. ³⁰⁷	Progress Notes
16	The progress note indicates the service provided was solely transportation. ³⁰⁸	Progress Notes
17	The progress note indicates the service provided was solely clerical. ³⁰⁹	Progress Notes
18	The progress note indicates the service provided was solely payee related. ³¹⁰	Progress Notes
19	No service provided; Left voicemail message reminder regarding appointment or follow-up. Missed appointment per DMH Letter No.02-07. ³¹¹	Progress Notes
20	For child/youth receiving TBS, the TBS progress notes overall clearly indicate that TBS was provided solely for one of the following reasons: ³¹² a. For the convenience of the family, caregivers, physician, or teacher; b. To provide supervision or to ensure compliance with terms and conditions of probation; c. To ensure the child's/youth's physical safety or the safety of others, e.g. suicide watch; and d. To address conditions that are not a part of the child's/youth's mental health condition.	Progress Notes
21	For child/youth receiving TBS, the progress note clearly indicates that TBS was provided to a child/youth in a hospital mental health unit, psychiatric health facility, or crisis residential facility. ³¹³	Progress Notes

Appendix 4

Lock-out Crosswalk

Type of Service → Service Site or During the Hours of Operation ↓	Lock-out Mental Health Services	Lock-out Medication Support Services	Lock-out Targeted Case Management Services
Crisis Residential	Yes ¹	No	No
Crisis Stabilization	Yes ²	Yes	No
Day Programs (Intensive and Rehabilitation)	No ³	Yes	No
Juvenile Hall, Jail, or Similar Detention (Not Adjudicated for Placement)	Yes ⁴	Yes ³	Yes ³
Psychiatric Inpatient Hospital (Free-Standing)	Yes ^{1, 4}	Yes	Yes ⁵
Psychiatric Inpatient Hospital (Psych Unit within General Physical Health-care Hospital that is Medi-Cal Certified)	Yes ¹	Yes	Yes ⁵
Psychiatric Health Facility (PHF)	Yes ¹	Yes	Yes ⁵
Psychiatric Nursing Facility	Yes ¹	Yes	Yes ⁵
Physical Health Care Hospital	No	No	No

¹ Except on the day of admission

² No other Specialty Mental Health Service is reimbursable during the same time period this service is reimbursed

³ Except by the same Day Treatment Program staff

⁴ Except when there is evidence that the court has ordered suitable placement (post-adjudication for placement) in a group home or other setting other than a correctional institution, jail and other similar settings.

⁵ Except on the day of admission, and 30 calendar days immediately prior to the day of discharge, for a maximum of three non-consecutive periods of 30 calendar days or less per continuous stay in the facility immediately prior to discharge for the purpose of placement

Appendix 5 Staffing Crosswalk

Program staffing must always commensurate with scope of practice and as dictated by the Mental Health Plan.¹

Staff Type Service Type	Physician	Psychologist	Pharmacist	Physician Assistant	LCSW	MFT	Registered ASW or MFT-Intern (IMF) ²	RN	LVN	PT	MHRS	Bachelors in Mental Health Field	Graduate Student or Trainee ³	Two years FTE in Mental Health	Less than 2 years Experience ⁴
Mental Health Services	X	X		O	X	X	X	X	X	X	X	X	O	X	O
Med Support Services	X		X	X				X	X	X					
Targeted Case Management	X	X	X	O	X	X	X	X	X	X	X	X	O	X	O
Day Treatment Intensive	X	X		O	X	X	X	X	X	X	X	X	O	X	O
Day Rehabilitation	X	X		O	X	X	X	X	X	X	X	X	O	X	O
Crisis Services	X	X		O	X	X	X	X	X	X	X	X	O	X	O
Psychological Testing	X	X		O	O	O	O						O		

Key: X = Permitted; O = MHP's Discretion

CCR, Title 9, Chapter 11, section 1840.344 Service Function Staffing Requirement - General

Mental Health Services, Day Rehabilitation Services, Day Treatment Intensive Services, Crisis Intervention Services, Targeted Case Management, and Adult Residential Treatment Services may be provided by any person determined by the MHP to be qualified to provide the service, consistent with state law.

¹ Mental Health Plans have the authority to further limit or restrict services as appropriate

² Under the supervision of a Licensed MD, PhD, LCSW, or MFT provided within scope of practice and training

³ Ibid.

⁴ Under appropriate supervision as directed by the MHP

Appendix 6

Local Contacts/DMH Letters and Information Notices/Resources

Local Contacts/Resources

Each County Mental Health/Behavioral Health division or department has a designated Quality Assurance or Management unit. It is recommended that providers seeking additional assistance contact this local resource for application of the concepts contained herein.

As a point of reference, County administrators may contact their designated State Department of Mental Health

Representatives for assistance. The following attached list contains information regarding these regional representatives. For updates and changes to these assigned contacts please reference the following DMH website for published updates to regional assignments:

<http://www.dmh.cahwnet.gov/DMHDocs/default.asp?view=letters>
or

<http://www.dmh.ca.gov/CountyOps/contact.asp>

Appendix 7

State Contacts/Resources

The following DMH County Support staff list is generally provided to the MHP and County Administrators.

Department of Mental Health County Support Branch Marjorie Glaviano, Chief (916) 654-3168 • Marjorie.Glaviano@dmh.ca.gov	
General Contact Information	
California Department of Mental Health County Operations Unit 1600 9th Street, Room 100 Sacramento, CA 95814	
Phone: (916) 654-3168 Fax: (916) 654-5591	
County Operations Section (North/Bay)	County Operations Section (South/Central)
Rebecca Kirby, Chief (916) 657-0291 • Rebecca.Kirby@dmh.ca.gov	John Lessley, Chief (916) 654-3535 • John.Lessley@dmh.ca.gov
Renee Jackson, Office Assistant (916) 654-2526 • Renee.Jackson@dmh.ca.gov	Cate England, Office Technician (916) 654-3168 • Catherine.England@dmh.ca.gov
Barbara Vick, Staff Services Analyst (916) 654-3589 • Barbara.Vick@dmh.ca.gov	Nicole Serrano, Staff Services Analyst (916) 654-6004 • Nicole.Serrano@dmh.ca.gov

Appendix 7 State Contacts/Resources

The following DMH County Support staff list is generally provided to the MHP and County Administrators.

County Liaisons	County Liaisons
Enrica Bertoldo, Staff Mental Health Specialist (916) 651-0570 • Enrica.Bertoldo@dmh.ca.gov	Linda Brophy, Associate Mental Health Specialist (916) 654-7357 • Linda.Brophy@dmh.ca.gov
Susan Brown, Associate Mental Health Specialist (916) 653-8672 • Susan.Brown@dmh.ca.gov	Erika Cristo, Staff Mental Health Specialist Phone: (916) 653-8759 • Erika.Cristo@dmh.ca.gov
Kathleen Carter Nishimura, Staff Mental Health Specialist Phone: (916) 651-6613 • Kathleen.Carter@dmh.ca.gov	Iris Frazier, Associate Mental Health Specialist Phone: (916) 651-9867 • Iris.Frazier@dmh.ca.gov
Patricia Coyle, Associate Mental Health Specialist (916) 651-0997 • Patricia.Coyle@dmh.ca.gov	Eddie Gabriel, Staff Mental Health Specialist Phone: (916) 654-3263 • Eddie.Gabriel@dmh.ca.gov
Harold Curtis, Associate Mental Health Specialist Phone: (916) 654-1206 • Harold.Curtis@dmh.ca.gov	Lori Hokerson, Staff Mental Health Specialist Phone: (916) 651-6296 • Lori.Hokerson@dmh.ca.gov
David Jones, Staff Mental Health Specialist Phone: (916) 654-3623 • David.Jones@dmh.ca.gov	Troy Konarski, Staff Mental Health Specialist Phone: (916) 654-2643 • Troy.Konarski@dmh.ca.gov
Wanda Kato, Staff Mental Health Specialist Phone: (916) 654-2644 • Wanda.Kato@dmh.ca.gov	Donna Ures, Associate Mental Health Specialist Phone: (916) 653-2634 • Donna.Ures@dmh.ca.gov
Duane Shaul, Associate Mental Health Specialist Phone: (916) 651-0999 • Duane.Shaul@dmh.ca.gov	[Redacted]

Appendix 8 Websites

The following public websites are available for all to access and to find additional relevant information and resources.

- California Institute for Mental Health (CiMH) - <http://www.cimh.org>
- DMH County Administrators and Providers - <http://www.dmh.cahwnet.gov/InfoAdminProv/default.asp>
- Program Compliance/System of Care Advisory Team (PSAT) (formerly Staff Work Advisory Team): Frequently Asked Questions - <http://www.dmh.cahwnet.gov/PSAT/faq.asp>

Appendix 9 Code References

The following Regulations, Laws and, Citations are arranged alphabetically according to the Regulation Area/Topic.

Title 9 (Quick Reference Index) Regulation or Law	Title	Code Section (§)	Regulation Area/Topic
California Code of Regulations	9	§1810.204	Assessment
California Code of Regulations	9	§1810.205	Beneficiary
California Code of Regulations	9	§1810.206	Collateral
California Code of Regulations	9	§1810.209	Crisis Intervention
California Code of Regulations	9	§1810.210	Crisis Stabilization
California Code of Regulations	9	§1810.211	Cultural Competence
California Code of Regulations	9	§1810.212	Day Rehabilitation
California Code of Regulations	9	§1810.213	Day Treatment Intensive
California Code of Regulations	9	§1810.215	EPSDT Supplemental Specialty Mental Health Services (i.e., Therapeutic Behavioral Services - TBS)
California Code of Regulations	9	§625	(Licensed Clinical) Social Worker [LCSW]
Code of Federal Regulations	42	§625	(Licensed Practitioner of the Healing Arts) [LPHA] Diagnostic, screening, preventative, and rehabilitative services

Appendix 9 Code References

The following Regulations, Laws and, Citations are arranged alphabetically according to the Regulation Area/Topic.

Title 9 (Quick Reference Index) Regulation or Law	Title	Code Section (§)	Regulation Area/Topic
California Code of Regulations	9	§626	Marriage and Family Therapist (formally Marriage, Family and Child Counselor) [MFT]
California Code of Regulations	9	§1830.205	Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services
California Code of Regulations	9	§1830.210	Medical Necessity Criteria for MHP Reimbursement for Specialty MHS for Eligible Beneficiaries Under 21 Years of Age
California Health and Safety Code	N/A	§123105(b)	Medical Record
California Code of Regulations	9	§1810.225	Medication Support Services
California Code of Regulations	9	§1810.226	Mental Health Plan
California Code of Regulations	9	§1810.227	Mental Health Services
California Code of Regulations	9	§630	Mental Health Rehabilitation Specialist
California Code of Regulations	9	§1840.312	Non-Reimbursable Services
California Code of Regulations	9	§1810.231	Organizational Provider
California Code of Regulations	9	§1810.232	Plan Development
California Code of Regulations	9	§623	Psychiatrist

Appendix 9 Code References

The following Regulations, Laws and, Citations are arranged alphabetically according to the Regulation Area/Topic.

Title 9 (Quick Reference Index) Regulation or Law	Title	Code Section (§)	Regulation Area/Topic
California Code of Regulations	9	§624	Psychologist
California Code of Regulations	9	§1810.243	Rehabilitation
California Code of Regulations	9	§782.44	Registered Nurse
California Code of Regulations	9	§1810.247	Specialty Mental Health Services
California Code of Regulations	9	§1810.246.1	Significant Support Person
California Code of Regulations	9	§1810.380 and §1810.385	State Oversight and Civil Penalties
California Code of Regulations	9	§1810.249	Targeted Case Management
California Code of Regulations	9	§1810.250	Therapy
California Code of Regulations	9	§1810.254	Waivered/Registered Professional (LPHA)

Appendix 10

Endnotes/Source Citation List

The following Endnotes are the source citations contained in this EPSDT reference manual.

- 1 "The Short-Doyle Act," Auerback, A., Western Journal of Medicine, CA. Med. 1959 May; 90(5): 335-338.
- 2 The Center for Human Services, UC Davis Extension, University of California, Davis, Fiscal Management, 01-12-07, page 4
- 3 "California Mental Health Master Plan: A Vision for California," California Mental Health Planning Council, March 2003.
- 4 California Welfare and Institution Code 5600.3
- 5 "Realignment Revisited: An Evaluation of the 1991 Experiment in State-County Relations", Hill, E.B. 2001, page 6-7.
- 6 "The Medicaid Rehabilitative Services ("Rehab") Option, Community Living Briefs, Vol. 3, Issue 2, 2006, page 1.
- 7 Medi-Cal Mental Health Policy (MCMHP): Consolidation and Managed Care, "Consolidation", 1999
- 8 "Medicaid Early and Periodic Screening and Diagnostic Treatment Benefit," Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services
- 9 Title 9, California Code of Regulations (CCR), Chapter 11, Section 1
- 10 Title 9, CCR, adopt: Chapter 11. Medi-Cal Specialty Mental Health Services
- 11 Medi-Cal Trend Report, Medi-Cal Mental Health Services in California, June 2001 and Utilization of the Medi-Cal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Benefit Report of 2001 Budget Act for Item 4440-101-0001
- 12 California Mental Health Financing 101, California Mental Health Director's Association presentation
- 13 DMH Letter No. 99-03 and 01-11
- 14 Description of TBS Services, September 1, 2006, Community Mental Health Block Grant Application
- 15 DMH Information Notice No. 07-08 and FY 2006-07 Trailer Bill Language on EPSDT Reviews and Assembly Bill 1807
- 16 California Planning Council, March 2003 California Mental Health Master Plan: A Vision for California, page 117.
- 17 Medi-Cal Mental Health Policy (MCMHP): Consolidation and Managed Care
- 18 CCR, Title 9, CCR, Sections 1810.380 and 1810.385.
- 19 MHP-DMH Contract Boiler Plate, Exhibit A and DMH Information Notice No. 04-08
- 20 CCR, Title 9, Chapter 11, Section 830.215
- 21 CCR, Title 9, Chapter 11, Section 1810.227
- 22 CCR, Title 9, Chapter 11, Section 1840.360 (b)
- 23 CCR, Title 9, Chapter 11, Section 1810.204
- 24 CCR, Title 9, Chapter 11, Section 1810.241 and Business and Professional Code Section 2909-2913
- 25 CCR, Title 9, Chapter 11, Section 1810.232
- 26 CCR, Title 9, Chapter 11, Section 1810.250
- 27 CCR, Title 9, Chapter 11, Section 1810.243
- 28 CCR, Title 9, Chapter 11, Section 1810.355(a)(3)
- 29 DMH Letter No. 01-01, page 3
- 30 DMH Letter No. 01-01, page 3
- 31 Ibid.
- 32 Ibid.
- 33 Medi-Cal Reimbursement of Collateral Services Provided to Significant Support Persons in Group Settings DMH Letter No. 07-03
- 34 CCR, Title 9, Chapter 11, Section 1810.206
- 35 CCR, Title 9, Chapter 11, Section 1810.246.1
- 36 CCR, Title 9, Chapter 11, Section 1840.314 (b)
- 37 CCR, Title 9, Chapter 11, Section 1840.324
- 38 DMH Info Notice No. 01-01, page 3
- 39 CCR, Title 9, Chapter 11, Section 1840.316
- 40 DMH Info Notice No. 01-01, page 3
- 41 CCR, Title 9, Chapter 11, Section 1840.316(b)(1)
- 42 According to NHIC Program Integrity unit, fiscal intermediary for CMS, June 14, 2007
- 43 Medi-Cal Reimbursement of Collateral Services Provided to Significant Support Persons in Group Settings DMH Letter No. 07-03 and CCR, Title 9, Chapter 11, Section 1840.314 (c)
- 44 Medi-Cal Reimbursement of Collateral Services Provided to Significant Support Persons in Group Settings DMH Letter No. 07-03
- 45 Ibid.
- 46 CCR, Title 9, Chapter 11, Section 1840.360
- 47 CCR, Title 9, Chapter 11, Section 1840.360 (b) and DMH Info Notice No. 02-06, page 3
- 48 CCR, Title 9, Chapter 11, Section 1810.216 and 1810.253
- 49 DMH Info Notice No. 02-06, page 3
- 50 CCR, Title 9, Chapter 11, Section 1840.364 and Section 1840.370
- 51 CCR, Title 9, Chapter 11, Section 1840.312(g)and(h) and Section 1840.360-374; CFR, Title 42, Sections 435.1008 and 435.1009; CCR, Title 22, Section 50273(1-9)
- 52 CCR, Title 9, Chapter 11, Section 1840.368
- 53 CCR, Title 9, Chapter 11, Section 1810.225
- 54 CCR, Title 9, Chapter 11, Section 1810.355
- 55 Ibid.
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- 57 CCR, Title 9, Chapter 11, Section 1840.316 and Section 1840.326
- 58 CCR, Title 9, Chapter 11, Section 1840.372
- 59 DMH Information Notice No. 02-06, page 3
- 60 CCR, Title 9, Chapter 11, Section 1840.370
- 61 CCR, Title 9, Chapter 11, Section 1840.326
- 62 CCR, Title 9, Chapter 11, Section 1840.346
- 63 CCR, Title 9, Chapter 11, Section 1810.225
- 64 MHP Contract with DMH, Exhibit A, Attachment 1, Appendix C, B(1)(f), page 38
- 65 CCR, Title 9, Chapter 11, Section 1810.213
- 66 CCR, Title 9, Chapter 11, Section 1840.318
- 67 CCR, Title 9, Chapter 11, Section 1840.318
- 68 DMH Information Notice No. 02-06 Attachment A
- 69 DMH Information Notice No. 02-06 Attachment A, Page 2
- 70 Ibid.
- 71 Ibid.
- 72 DMH Information Notice No. 02-06, page 4
- 73 DMH Information Notice No. 02-06, Attachment A
- 74 DMH Information Notice No. 02-06, Attachment A
- 75 DMH Information Notice No. 03-03, page 2
- 76 DMH Information Notice No. 02-06, Attachment A, page 2
- 77 DMH Information Notice No. 02-06 Attachment A
- 78 Ibid.
- 79 Ibid.
- 80 Ibid.
- 81 Ibid.
- 82 DMH Information Notice No. 02-06 Attachment A, page 1
- 83 DMH Information Notice No. 02-06 Attachment A, page 3
- 84 CCR, Title 9, Chapter 11, Section 1840.328
- 85 CCR, Title 9, Chapter 11, Section 1840.318(b)(1-2)
- 86 DMH Letter No. 03-03
- 87 DMH Information Notice No. 02-06 Attachment A
- 88 DMH Information Notice No. 02-06, Attachment A and DMH Letter No. 02-08, page 9
- 89 DMH Information Notice No. 02-06, Attachment A
- 90 DMH Information Notice No. 02-06, page 3
- 91 CCR, Title 9, Chapter 11, Section 1840.318
- 92 MHP Contract with DMH, Exhibit A, Attachment 1, Section W
- 93 CCR, Title 9, Chapter 11, Section 1840.318
- 94 DMH Letter No. 03-03, page 2
- 95 DMH Letter No. 03-03, page 4, Attachment 1 and MHP Contract with DMH, Exhibit A, Attachment 1, Section W, (4)(f)
- 96 DMH Information Notice No. 02-06, page 2
- 97 MHP Contract with DMH, Exhibit A, Attachment 1, Section W and DMH Notice No. 02-06
- 98 MHP Contract with DMH, Exhibit A, Attachment 1, page 18
- 99 Ibid.
- 100 DMH Information Notice No. 02-08, page 10
- 101 CCR, Title 9, Chapter 11, Section 1840.360
- 102 Ibid.
- 103 Ibid.
- 104 CCR, Title 9, Chapter 11, 1840.350
- 105 DMH Letter No. 03-03, page 2
- 106 Authority: Welfare and Institutions 14680 and Welfare and Institution 5778
- 107 CCR, Title 9, Chapter 11, 1840.350
- 108 DMH Information Notice No. 02-06, page 3
- 109 CCR, Title 9, Chapter 11, 1840.350
- 110 DMH Information Notice No. 02-06, page 4
- 111 DMH Information Notice No. 02-06, Attachment A, page 3
- 112 CCR, Title 9, Chapter 11, Section 1810.212
- 113 CCR, Title 9, Chapter 11, Section 1840.318(b)(3)
- 114 DMH Information Notice No. 02-06, page 2
- 115 DMH Information Notice No. 02-06, page 3
- 116 MHP Contract with DMH, Exhibit A, Attachment 1, page 17 and page 18
- 117 DMH Letter No. 03-03
- 118 DMH Information Notice No. 02-06, Attachment A
- 119 DMH Information Notice No. 02-06, Attachment A
- 120 DMH Information Notice No. 02-06, Attachment A, page 2
- 121 MHP Contract with DMH, Exhibit A, Attachment 1, Section W
- 122 Ibid.
- 123 Ibid.
- 124 DMH Information Notice No. 02-06 Attachment A
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- 129 DMH Letter No. 03-03
- 130 DMH Information Notice No. 02-06 Attachment A
- 131 MHP Contract with DMH, Exhibit A, Attachment 1, Section W, (6), page 21
- 132 DMH Information Notice No. 02-06, page 3
- 133 Ibid.
- 134 DMH Letter No. 03-03, page 2

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- ¹³⁵ MHP Contract with DMH, Exhibit A, Attachment 1, Section W and DMH Notice No. 02-06
- ¹³⁶ MHP Contract with DMH, Exhibit A, Attachment 1, page 18
- ¹³⁷ Ibid.
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- ¹³⁹ MHP Contract with DMH, Exhibit A, Attachment 1, page 18
- ¹⁴⁰ DMH Information Notice No. 02-06, page 2
- ¹⁴¹ CCR, Title 9, Chapter 11, Section 1840.360
- ¹⁴² CCR, Title 9, Chapter 11, Section 1840.360
- ¹⁴³ Ibid.
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- ¹⁴⁵ CCR, Title 9, Chapter 11, Section 1840.352
- ¹⁴⁶ DMH Letter No. 03-03, page 2
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- ¹⁴⁸ CCR, Title 9, Chapter 11, Section 1810.215
- ¹⁴⁹ MHP Contract with DMH, Exhibit A, Attachment 1, Section X and DMH Letter No. 99-03, page 3
- ¹⁵⁰ DMH Letter No. 01-04, page 2
- ¹⁵¹ DMH Letter No. 99-03, page 1
- ¹⁵² DMH Letter No. 99-03, page 3 and 4
- ¹⁵³ DMH Letter No. 99-03, page 4
- ¹⁵⁴ DMH Letter No. 99-03
- ¹⁵⁵ DMH Letter No. 04-12
- ¹⁵⁶ DMH Information Notice No. 00-03, page 2
- ¹⁵⁷ DMH Letter No. 99-03, page 4
- ¹⁵⁸ DMH Letter No. 99-03, page 5
- ¹⁵⁹ DMH Information Notice No. 02-08, page 9
- ¹⁶⁰ DMH Letter No. 99-03, page 3
- ¹⁶¹ DMH Letter No. 99-03, page 7-8
- ¹⁶² DMH Letter No. 99-03, page 3
- ¹⁶³ DMH Letter No. 99-03, page 5
- ¹⁶⁴ DMH Letter No. 99-03
- ¹⁶⁵ MHP Contract with DMH, Exhibit A, Attachment 1, Section X and DMH Letter No. 99-03, page 3
- ¹⁶⁶ DMH Information Notice No. 02-08, page 8
- ¹⁶⁷ CCR, Title 9, Chapter 11, Section 1840.316
- ¹⁶⁸ DMH Letter No. 99-03, page 3
- ¹⁶⁹ DMH Information Notice No. 02-06, page 3
- ¹⁷⁰ CCR, Title 9, Chapter 11, Section 1840.364 and Section 1840.370
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- ¹⁷³ DMH Letter No. 01-01
- ¹⁷⁴ MHP Contract with DMH, Exhibit A, CCR, Title 9, Chapter 11, Section 1810.435
- ¹⁷⁵ DMH Information Notice No. 02-08, page 10
- ¹⁷⁶ DMH Information Notice No. 02-08, page 5-8
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- ¹⁸³ DMH Information Notice No. 02-08, page 6
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- ¹⁸⁶ DMH Information Notice 02-08, page 9
- ¹⁸⁷ DMH Letter No. 99-03
- ¹⁸⁸ DMH Letter No. 99-03, Attachment 2
- ¹⁸⁹ CCR, Title 9, Chapter 11, Section 1810.209
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- ¹⁹⁷ CCR, Title 9, Chapter 11, Section 1840.322
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- ¹⁹⁹ CCR, Title 9, Chapter 11, Section 1840.368
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- ²⁰¹ Ibid.
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- ²⁰³ Ibid.
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- ²⁰⁸ CCR, Title 9, Chapter 11, Section 1840.314
- ²⁰⁹ Ibid.

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- 210 CCR, Title 9, Chapter 11, Section 1840.314 and Section 1810.435
- 211 CCR, Title 9, Chapter 11, Section 1840.314
- 212 CCR, Title 9, Chapter 11, Section 1840.316
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- 214 DMH Information Notice No. 02-06, Page 3
- 215 CCR, Title 9, Chapter 11, Section 1840.322
- 216 CCR, Title 9, Chapter 11, Section 1840.312
- 217 DMH FFP Reasons for Recoupment, FY 05-06, CCR, Title 9, Chapter 11, Section 1810.355 and CCR, Title 9, Chapter 11, Section 1840.312
- 218 DMH Letter No. 02-07
- 219 CCR, Title 9, Chapter 11, Section 1840.312(f), 1810.247, 1810.110(a), and 1830.205(b)(3)
- 220 CCR, Title 9, Chapter 11, Section 1840.312(f), 1810.247, 1840.110(a), and 1830.205(b)(3)
- 221 DMH Letter 01-01
- 222 CCR, Title 9, Chapter 11, Section 1810.355
- 223 CCR, Title 9, Chapter 11, Section 1840.312
- 224 CCR, Title 9, Chapter 11, Section 1810.355(a)(1)(B), 1840.312(f), 1810.247, and 1840.110(a)
- 225 DMH Letter No. 99-03, page 5
- 226 DMH Letter No. 99-03, page 4
- 227 Section I Non-Hospital Chart Review-EPSTDT Reviews in FY 06-07 and MHP Contract with DMH, Exhibit A, Attachment 1, Appendix C
- 228 MHP Contract with DMH, Exhibit A, Attachment 1, Appendix C, page 39
- 229 CCR, Title 22, Chapter 7.2, Section 75343 and MHP Contract with DMH, Exhibit A, Attachment 1, Appendix C, page 39
- 230 CCR, Title 9, Chapter 11, Section 1810.314(b)
- 231 MHP Contract with DMH, Exhibit A, Attachment 1, Appendix C, page 39
- 232 MHP Contract with DMH, Exhibit A, Attachment 1, Appendix C
- 233 DMH Letter No. 99-03, page 6
- 234 CCR, Title 9, Chapter 11, Section 1810.205 and Section 1830.210
- 235 CCR, Title 9, Chapter 11, Section 1830.205(b)(1)(A-R) and MHP Contract with DMH, Exhibit A, Attachment 1, Table 1
- 236 CCR, Title 22, Section 51340(e)(3)
- 237 DMH Letter 01-04, Attachment 1
- 238 CCR, Title 9, Chapter 11, Section 1810.204, MHP Contract with DMH, Exhibit A, Attachment 1, Appendix C, and Section J Non-Hospital Chart Review-EPSTDT
- 239 MHP Contract with DMH, Exhibit A, Attachment 1, Appendix C
- 240 Ibid.
- 241 DMH Program Compliance/Staff Work Advisory Team (SWAT formerly PSAT) under “Claiming and Billing”(A18)
- 242 Ibid.
- 243 CCR, Title 9, Chapter 11, Section 1830.205(b), Section 1830.210 (a) and Section J Non-hospital Chart Review-EPSTDT, DMH Letter No. 99-03, pages 6-7
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- 245 DMH Letter 02-01 MHP Contract with DMH, Exhibit A, Attachment 1, Appendix C (Documentation Standards for Client Records)
- 246 Ibid.
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- 248 DMH Review Protocol, FY 06-05, page 50, item 1c(5)
- 249 DMH Letter 02-01, page 3
- 250 DMH Review Protocol, FY 06-05, page 55, item 3e
- 251 MHP Contract with DMH, Exhibit A, Attachment 1, Appendix C, page 37
- 252 MHP Contract with DMH, Exhibit A, Attachment 1, Appendix C, page 38, item (1) (f)
- 253 DMH Letter 02-01 MHP Contract with DMH, Exhibit A, Attachment 1, Appendix C (Documentation Standards for Client Records)
- 254 MHP Contract with DMH, Exhibit A, Attachment 1, Appendix C
- 255 MHP Contract with DMH, Exhibit A, Attachment 1, Appendix C, page 38
- 256 CCR, Title 9, Chapter 11, Section 1810.216
- 257 CCR, Title 9, Chapter 11, Section 1810.253
- 258 MHP Contract with DMH, Exhibit A, Attachment 1, Appendix C, Pg 38, (C), (1), (a)
- 259 DMH Program Compliance/Staff Work Advisory Team (SWAT formerly PSAT) under “Claiming and Billing”
- 260 CCR, Title 9, Chapter 11, Section 1840.316
- 261 45 CFR Parts 160 and 164 (HIPAA Privacy Final Rule), 45 CFR Parts 160, 162 and 164 (HIPAA Security Final Rule), and Civil Code 56.10
- 262 California Health and Safety Code (H&S) 123105(b) and 123149
- 263 California Civil Code (CC) 1798.48 and Title 22, Licensing and Certification, Section 77143
- 264 45 CFR Parts 160 and 164 (HIPAA Privacy Final Rule), 45 CFR Parts 160, 162 and 164 (HIPAA Security Final Rule)
- 265 California Health and Safety Code 123145, and CCR Title 22, Licensing and Certification dictates under section 77143
- 266 DMH Information Notice No. 06-07

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- ²⁶⁷ Title 22, Chapter 2 Section 71551c, Title 22, Chapter 3 Section 71551a and Health and Safety Code 123145
- ²⁶⁸ California Civil Code 56.10
- ²⁶⁹ MHP Contract with DMH, Exhibit A, Attachment 1, Appendix C, page 39, items (f) and (g)
- ²⁷⁰ MHP Contract with DMH, Exhibit A, Attachment 1, Appendix C, page 39, item (f)
- ²⁷¹ CCR, Title 9, Chapter 11, Section 1830.215 and Section J (4e) Non-Hospital Chart Review-EPSDT Reviews FY 06-07
- ²⁷² Welfare and Institution Code 5600(a), Business and Professional Code 2051-2052, CCR, Title 9, Chapter 11, Section 623 and CCR, Title 9, Chapter 3.5 Section 782.39
- ²⁷³ Welfare and Institution Code 5600(a), Business and Professional Code 2902, CCR, Title 9, Chapter 11, Section 624 and CCR, Title 9, Chapter 3.5 Section 782.4
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- ²⁸³ CCR, Title 9 Section 550
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- ²⁹¹ MHP Contract with DMH, Exhibit A, Attachment 1, Appendix A
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- ²⁹³ DMH Reasons for Recoupment, EPSDT Review in FY 05-06
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- ²⁹⁷ CCR, Title 9, Chapter 11, Section 1830.205(b)(3)(B)(1),(2), and (3)
- ²⁹⁸ MHP Contract with DMH, Exhibit A, Attachment 1, Appendix C
- ²⁹⁹ Ibid.
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- ³⁰¹ CCR, Title 9, Chapter 11, Section 1810.440(c); MHP Contract with DMH, Exhibit A, Attachment 1, Appendix C
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- ³⁰⁶ CCR, Title 9, Chapter 11, Sections 1840.316 (b)(2)
- ³⁰⁷ MHP Contract with DMH, Exhibit A, Attachment 1, Appendix C
- ³⁰⁸ CCR, Title 9, Chapter 11, Sections 1810.355 (a)(1)(B), 1840.312(f), and 1810.247, and 1840.110(a)
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- ³¹⁰ Ibid.
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The California Institute for Mental Health is a non-profit public interest corporation established for the purpose of promoting excellence in mental health. CiMH is dedicated to a vision of “a community and mental health services system which provides recovery and full social integration for persons with psychiatric disabilities; sustains and supports families and children; and promotes mental health wellness.”

Based in Sacramento, CiMH has launched numerous public policy projects to inform and provide policy research and options to both policy makers and providers. CiMH also provides technical assistance, training services, and the Cathie Wright Technical Assistance Center under contract to the California State Department of Mental Health.