STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

PETE WILSON, *Governor*

DEPARTMENT OF MENTAL HEALTH
1600 - 9TH STREET
SACRAMENTO, CA 95814

(916)654-2309

July 27, 1995

DMH LETTER NO.: 95-04

TO: LOCAL MENTAL HEALTH DIRECTORS
LOCAL MENTAL HEALTH PROGRAM CHIEFS
LOCAL MENTAL HEALTH ADMINISTRATORS
COUNTY ADMINISTRATIVE OFFICERS
CHAIRPERSONS, LOCAL MENTAL HEALTH BOARDS

SUBJECT: SHORT-DOYLE/MEDI-CAL MODIFICATIONS/REVISIONS FOR THE REHABILITATION OPTION AND TARGETED CASE MANAGEMENT MANUAL, DMH LETTER NO. 94-14, DATED JULY 7, 1994

EXPIRES: Retain Until Rescinded

The Department of Mental Health (DMH) has completed a revision of the Short-Doyle/Medi-Cal Manual for the Rehabilitation Option and Targeted Case Management. Requirements contained in this manual revision are effective statewide as of July 1, 1995.

This letter applies to Chapters 1, 2, 4, 5 and 7. Revisions to Chapter 6 are still under consideration. When finalized, they will be forwarded under a separate DMH letter.

Copies of the summary of revisions with page number references and manual replacement pages are being sent to each mental health director and each county quality improvement coordinator. For your convenience, this revision package includes all pages that have been changed. The page numbers have remained the same so that you may extract the old pages and insert the new.

If you would like an extra copy of these revisions, please call Technical Assistance and Training at (916) 654-2526.

STEPHEN W. MAYBERG, Ph.D
Director

Enclosures

cc: California Mental Health Planning Council
Chief, Technical Assistance and Training

JUNE 26,1995

SUMMARY OF MODIFICATION/REVISIONS
"REHAB OPTION" MANUAL

Note: Revisions are in bold. Page numbers shown are from the manual revised 7/1/94.

INTRODUCTION: Chapter 1

Page 1-4 Normalization: (Change to read) foster INDEPENDENCE (not DEPENDENCE).

SERVICE DEFINITIONS: Chapter 2

Page 2-3 Key points Applicable to All Services, sixth bullet: (ADD) CASE MANAGEMENT/BROKERAGE.

Page 2-4 Services Based on Staff Time, third bullet: (Delete) SHALL NOT BE BILLED SEPARATELY.

Page 2-7 Non-reimbursable Activities, sixth bullet: Transportation of an Individual (Delete) WHEN NO REIMBURSABLE SERVICE IS PROVIDED DURING OR SUBSEQUENT TO THE TRANSPORTATION. (Insert) TO A SERVICE IS NOT REIMBURSABLE BY SD/MC. THE TRANSPORTATION COSTS COULD BE FACTORED INTO THE OVERALL EXPENSE (RATE) OF PROVIDING A SD/MC SERVICE.

Page 2-29 Crisis Intervention, lockouts: (Delete) THE LAST SENTENCE. (Replace with) THE MAXIMUM AMOUNT BILLABLE FOR CRISIS INTERVENTION IN A 24 HOUR PERIOD, IS 20 HOURS.

Page 2-31 Crisis Stabilization, Emergency room, under site and contract requirements #1, first sentence: (Change) the word IN to AT.

Page 2-32 Crisis stabilization, Emergency room, first box note: (Insert) THE MAXIMUM NUMBER OF HOURS BILLABLE FOR CRISIS STABILIZATION EMERGENCY ROOM, IN A 24 HOUR PERIOD, IS 20 HOURS.

Page 2-35 Crisis Stabilization, Urgent Care, first box note: (Insert) THE MAXIMUM NUMBER OF HOURS BILLABLE FOR CRISIS STABILIZATION URGENT CARE, IN A 24 HOUR PERIOD, IS 20 HOURS.

Page 2-38 Psychiatric Health Facility, (Delete the box note): INCLUSION OF PSYCHIATRIC HEALTH FACILITY SERVICES IS CONTINGENT ON APPROVAL OF A MEDI-CAL STATE PLAN AMENDMENT BY HCFA. (The state plan has been amended).

Page 4-30 Coordination Plan, Frequency, sixth bullet, Annually according to the Month of Intake Schedule: (Add) THE WINDOW PERIOD APPLIES TO ANNUAL REWRITE.

Page 4-31 Service Plan, last diamond: (Delete) the last diamond. DATE OF FIRST CONTACT WITH PLANNED SERVICE.

Page 4-31 Service Plan, above the first diamond: (Add) SERVICE PLAN IS NOT REQUIRED FOR THE COORDINATOR TO PROVIDE COORDINATION RELATED ACTIVITIES.

Page 4-32 Service Plan, third bullet, last sentence: (Add) THE WINDOW PERIOD APPLIES TO THE SIX MONTH UPDATES AND THE ANNUAL REWRITE.

Page 4-33 Progress Notes, Intake Period: (Add) FOR SPECIFIC TYPES OF SERVICES, FOLLOW THE MINIMUM DOCUMENTATION FOR THAT TYPE OF SERVICE.

TRADITIONAL QUALITY ASSURANCE: Chapter 5

Page 5-11 Top of page (Add) UNIT OF SERVICE : UNITS ARE A MEANS OF MEASURING THE VOLUME OF SERVICES PROVIDED, SUCH AS A CONTACT, A VISIT OR A DAY.

Mental Health Services:

Initial VISITS: (Change to read) Initial UNITS:

Within the initial six month period, URC approval must be obtained (Delete) PRIOR TO THE END OF THE FIRST 30 DAYS OR 25 UNITS, WHICHEVER COMES FIRST. (Add) PRIOR TO THE 25TH UNIT OF SERVICE. URC authorization shall be for a maximum of 24 unit of service, for contact with significant others may be granted.

Exempt VISITS: (Change to read) Exempt UNITS:

Extended VISITS: (Change to read) Extended UNITS:

(Change) VISITS to UNITS OF SERVICE, TO READ AS FOLLOWS:

The URC has the authority to approve extended UNITS OF SERVICE. Prior to the end of the previously authorized units of service in a 6 month period, the URC may, after review of appropriate clinical justification in the Individual record or resume, authorize up to a maximum of 24 additional units of service which shall be valid only during the current 6 month period. For children's services, an additional 24 units of services, for contact with significant others may be granted. The URC may authorize additional increments of up to a specified number of units of services as needed within a 6 month period. Extended UNITS OF SERVICE, DURING THE CURRENT PERIOD, are effective on the date the URC meets and approves the URC request.

Page 2-39 Targeted Case Management/Brokerage, Linkage and Consultation: (Add a new bullet) *PLAN DEVELOPMENT.

Page 2-42 Comparison of Case Management/Brokerage under Clinic and Rehab Option, *Last Paragraph: (Add) CASE MANAGEMENT/BROKERAGE

Page 2-44 (Grid): (Add) AN * ABOVE THE COLUMN FOR MEDICATION SUPPORT. (Add) *** TO THE LEFT SIDE COLUMN FOR CRISIS STABILIZATION EMERGENCY ROOM & URGENT CARE.

Page 2-44 (Grid) bottom line: (Add) ** MAX PER 24 HOUR PERIOD IS $1,234 and (Add) *** MAX HOURS PER 24 HOUR PERIOD IS 20.

COORDINATED SERVICES: Chapter 4

Page 4-20 Medication Monitoring, Requirements #1.: Sample size must be at least five percent {5%} (Add) ANNUALLY.

Page 4-21 Medication Monitoring, #4a. first sentence: (Change) OUR to OR.

Page 4-23 (Grid) Approval of Service Type, CM/B, Under New Traditional QA: (Delete) THE REQUIREMENT OF 30 DAYS AND 6 MONTHS. (Replace with) NA. (Delete) ** BY UTILIZATION REVIEW COMMITTEE OR COORDINATOR.

Page 4-23 (Grid) Service Plan Duration, DTI, UNDER NEW TRADITIONAL QA: (Change) TX PLAN 3 MONTHS TO TX PLAN 6 MONTHS.

Page 4-24 (Grid) ADD A NEW FOOTNOTE *SERVICE PLANS WITHOUT CHANGES DO NOT REQUIRE THE COORDINATOR'S APPROVAL FOR 6 MONTH UPDATES. ANNUALLY THE COORDINATOR MUST APPROVE ALL SERVICE PLANS.

Page 4-24 (Grid) Plan Approval, under Coordinated Services: (Add) AN * BY EACH COORDINATOR.

Page 4-25 (Grid) UR requirements, Case Management/Brokerage, New traditional QA: (Delete) 30 DAYS AND 6 MONTHS (Insert) NA

Page 4-25 (Grid) Window Period, under Old QA and New Traditional QA: (Add) TX PLAN AND SERVICE PLAN.

Page 4-28 Community Functioning Evaluation, second bullet, Annually updated according to the month of Intake Schedule: (Add) THE WINDOW PERIOD APPLIES TO ANNUAL UPDATE.

Page 4-28 Community Functioning Evaluation, Frequency: (Add a new bullet) FOR INDIVIDUAL RECEIVING MEDICATION SUPPORT ONLY, THE COMMUNITY FUNCTIONING EVALUATION MAY BE DOCUMENTED IN THE PROGRESS NOTES.

Page 5-11

Extended services for the next 6 months may be authorized no earlier than 15 days prior to the beginning of the period without invalidating authorized units of service remaining in the current 6 month period.

Approved UNITS OF SERVICE for the next 6 month period must be identified as such by the URC. Unused approved units of service cannot be carried over to the next 6 month period.

Page 5-12

Prior Approval:

The need for prior approval by the URC relative to the initial unit of service in a new 6 month period is determined by the number of units of service in the preceding period. URC action is required if more than 24 units of service occurred during the preceding 6 month period. (Delete) EXTENDED UNITS ARE EFFECTIVE ON THE DATE URC MEETS AND APPROVES THE REQUEST.

Day Treatment Intensive:

Initial VISITS: (Change to read) Initial UNITS:

The initial URC approval must be obtained prior to (Delete) THE END OF THE FIRST 30 DAYS OR 15 UNITS, WHICHEVER COMES FIRST. (Add) THE 16TH UNIT OF SERVICE. URC authorization shall be for a maximum of 30 UNIT increments.

Extended VISITS/SERVICE: (Change to read) Extended UNITS:

(Change) VISITS/SERVICES to UNITS OF SERVICE.

The URC has the authority to approve extended UNITS OF SERVICE. Prior to the last day of the previously approved units of service, the URC may, after review of appropriate clinical justification in the Individual record or resume, authorize up to a maximum of 30 additional units of service. These extended units are effective on the date the URC meets and approves the request.

(Delete the next paragraph) EXTENDED SERVICES MAY BE AUTHORIZED NO EARLIER THAN 15 DAYS PRIOR TO THE BEGINNING OF THE NEXT AUTHORIZED PERIOD WITHOUT INVALIDATING THE AUTHORIZED UNITS OF SERVICE REMAINING. APPROVED UNITS OF SERVICE MUST BE IDENTIFIED AS SUCH BY THE URC.

Prior Approval:

(Change) VISITS to UNITS OF SERVICE.

Prior approval for this service function is always needed for extended UNITS OF SERVICE.

Page 5-12

Day Rehabilitation:

The initial URC approval must be obtained prior to (Delete) THE END OF THE FIRST 30 DAYS OR 15 UNITS, WHICHEVER COMES FIRST. (Add) THE 16TH UNIT OF SERVICE. URC authorization shall be for a maximum of 3 month increments.

Page 5-13

Extended VISITS/SERVICES (Change to read) Extended UNITS:

The URC has the authority to approve extended UNITS OF SERVICE. Prior to the end of the previously authorized time period, the URC may, after review of appropriate clinical justification in the Individual record or resume, authorize up to a maximum of 3 additional months. (Delete) THESE EXTENDED VISITS ARE EFFECTIVE ON THE DATE THE URC MEETS AND APPROVES THE REQUEST.

Prior Approval:

(Change) VISITS to UNITS OF SERVICE.

Prior approval for this service function is always needed for extended UNITS OF SERVICE.

Page 5-13

Adult Residential Treatment:

Initial VISITS/SERVICES (Change to read) Initial UNITS:

URC approval must be obtained prior to (Delete) THE END OF THE FIRST 30 DAYS OR 15 UNITS, WHICHEVER COMES FIRST. (Add) THE 16TH UNIT OF SERVICE. URC authorization shall be for a maximum of 6 month increments.

Extended Visits: (Change to read) Extended UNITS:

(Change) VISITS/SERVICES to UNITS OF SERVICE.

The URC has the authority to approve extended UNITS OF SERVICE. Prior to the end of the previously authorized time period, the URC may, after review of appropriate clinical justification in the Individual record or resume, authorize up to a maximum of 6 additional months. (Delete) EXTENDED SERVICES ARE EFFECTIVE ON THE DATE URC MEETS AND APPROVES THE REQUEST.

Extended UNITS OF SERVICE may be authorized no earlier than 15 days prior to the beginning of the next authorized period without invalidating the authorized units of service remaining. Approved units of service for the next period must be identified as such by the URC.

Page 5-13

Prior Approval:

(Change) VISITS to UNITS OF SERVICE.

Prior approval for this service function is always needed for extended UNITS OF SERVICE.

Page 5-14

Crisis Residential:

Initial VISITS/SERVICES: (Change to read) Initial UNITS:

Extended VISITS/SERVICES (Change to read) Extended UNITS:

(Change) VISITS/SERVICES to UNITS OF SERVICES.

The URC has the authority to approve extended UNITS OF SERVICE. Prior to the end of the previously authorized time period, the URC may, after review of appropriate clinical justification in the record or resume, authorize up to a maximum of 14 UNITS OF SERVICE. Extended UNITS OF SERVICE are effective on the date the URC meets and approves the request.

Prior Approval:

(Change) VISITS to UNITS OF SERVICE.

Prior approval for this service function is always needed for extended UNITS OF SERVICE.

Page 5-14 (Underline) REQUEST FOR URC ACTION AND NOTICE OF URC ACTION

Page 5-14 Case Management/Brokerage:

(Add) CASE MANAGEMENT/BROKERAGE DOES NOT REQUIRE URC AUTHORIZATION.

Page 5-14 Case Management/Brokerage: (Delete) THE UR REQUIREMENT FOR CASE MANAGEMENT/BROKERAGE.

Page 5-15 (Delete) INITIAL SERVICE PERIOD AND EXTENDED SERVICE PERIODS FOR CASE MANAGEMENT/BROKERAGE.

Page 5-15 (Underline) APPEALS AND CONFIDENTIALITY.

Page 5-16 (Grid) Service plan duration for Day Treatment Intensive, under the New Traditional QA, TX plan duration: (Change) THE TX. PLAN DURATION FROM 3 MONTHS TO 6 MONTHS. (As documented on page 5-21 last paragraph).

Page 5-16 (Grid) Approval of Services, CM/B, New Traditional: (Delete) 30 DAYS AND 6 MONTHS (Insert) NA.

Page 5-16 (Grid) Approval of Services, under New Traditional QA: (Delete) ** BY UTILIZATION REVIEW COMMITTEE OR COORDINATOR.

Page 5-17 (Grid): ADD FOOTNOTE * SERVICE PLAN UPDATES WITHOUT CHANGES DO NOT REQUIRE THE COORDINATOR'S APPROVAL FOR 6 MONTH UPDATES. ANNUALLY THE COORDINATOR MUST APPROVE ALL SERVICE PLANS.

Page 5-17 (Grid) Plan Approval, top right box under Coordinated Services. (Add) AN * BY EACH COORDINATOR.

Page 5-18 (Grid) Window period, Old QA and New Traditional QA: (Add) TX PLAN/SERVICE PLAN TO THE WINDOW PERIOD.

Page 5-18 (Grid) UR requirements, Case Management/Brokerage, New Traditional QA: (Delete) 30 days and 6 months. (Insert) NA

Page 5-21 Plans, first Paragraph: (Add) FOR CRISIS RESIDENTIAL TREATMENT, THE TREATMENT PLAN MUST BE COMPLETED WITHIN 72 HOURS OF ADMISSION.

CHAPTER 7

Page 7-2 & 7-3 Public school: Define contents of the "written Narrative": (Add) THE NARRATIVE MAY INCLUDE THE TYPE OF PROGRAM, OBJECTIVES, LOCATION, DAYS AND HOURS OF OPERATION, SERVICES PROVIDED, STAFF ASSIGNED BY DISCIPLINE, TARGET POPULATION, PROGRAM CAPACITY, ADMISSION AND DISCHARGE CRITERIA, AND ANY UNIQUE COMPONENTS.

Page 7-3 Social Rehabilitation Facility/Program Certification: (Delete) (REFER TO PAGES 7-11 AND 7-12) (Add) (REFER TO PAGES 7-8 AND 7-9).

Page 7-4 Administrative Policies: (Add) REPORTING OF UNUSUAL OCCURRENCES RELATING TO HEALTH AND SAFETY ISSUES.

Page 7-6 Staffing, #2 Head of Service: Each Provider shall have a staff person who meets the requirements specified in Title 9 (Add) SECTION 622 - 630.

Page 7-9 Application Information, #3: (Delete) "APPLICATION FOR PROVIDER CERTIFICATION AND LICENSED AS SOCIAL REHABILITATION PROGRAM/FACILITIES" (Replace with) "REQUESTS FOR PARTICIPATION" (see page 7-8).

PAGE 7-10 SD/MC Modes of Service: Moved from page 7-12.

Page 7-11 Recertification: Confirmation of continued compliance with all SD/MC requirements. Routine SD/MC provider recertification (Add) REVIEWS WHICH ARE DONE EVERY TWO YEARS, are based on DMH, Medi-Cal Oversight's Regional recertification REVIEW schedule. Additional certification REVIEWS may become necessary if:

Page 7-11 Recertification, "C" The Provider adds (Add) DAY TREATMENT OR MEDICATION SUPPORT SERVICES WHEN MEDICATIONS WILL BE ADMINISTERED OR DISPENSED FROM THE PROVIDER SITE.

Page 7-11 Recertification, "D" There are significant changes to the physical plant of the provider site: (Add) SOME PHYSICAL PLANT CHANGES COULD REQUIRE A NEW FIRE CLEARANCE.

Page 7-11 Recertification, the paragraph after item G: (Delete) THE LOCAL MENTAL HEALTH DIRECTOR OR DESIGNEE SHALL NOTIFY THE APPROPRIATE DMH, MEDI-CAL OVERSIGHT CHIEF (SEE PAGE 7-8) 60 DAYS PRIOR TO THE CHANGES OUTLINED IN (A) THROUGH (E) ABOVE. (INVOLUNTARY CHANGES DUE TO DISASTER SHALL BE REPORTED AS SOON AS POSSIBLE.) FAILURE TO DO SO MAY RESULT IN DECERTIFICATION.

Page 7-12 REPORTING UNUSUAL OCCURRENCES:
CONTINUED PARTICIPATION IN THE SD/MC PROGRAM REQUIRES THAT PROVIDERS REPORT UNUSUAL OCCURRENCES TO THE DMH MEDI-CAL OVERSIGHT REGIONAL OFFICE. AN UNUSUAL OCCURRENCE IS ANY EVENT WHICH JEOPARDIZES THE HEALTH AND/OR SAFETY OF CLIENTS, STAFF AND/OR MEMBERS OF THE COMMUNITY; INCLUDING BUT NOT LIMITED TO PHYSICAL INJURY AND DEATH.

UNUSUAL OCCURRENCES ARE TO BE REPORTED TO DMH WITHIN FIVE CALENDAR DAYS OF EVENT OR AS SOON AS POSSIBLE AFTER BECOMING AWARE OF THE UNUSUAL EVENT.

REPORTS ARE TO INCLUDE THE FOLLOWING ELEMENTS:

1. COMPLETE WRITTEN DESCRIPTION OF EVENT INCLUDING OUTCOME.

2. WRITTEN REPORT OF PROVIDERS INVESTIGATION AND CONCLUSIONS.

3. LIST OF PERSONS DIRECTLY INVOLVED AND/OR DIRECT KNOWLEDGE OF EVENT.

THE DEPARTMENT RETAINS THE RIGHT TO INDEPENDENTLY INVESTIGATE UNUSUAL OCCURRENCES WITH THE COOPERATION OF THE PROVIDER.

Page 7-14 HEADING: (Delete) CHANGE OF OWNERSHIP OR LOCATION (Replace with) CHANGE OF OWNERSHIP OR LOCATION AND PROGRAM CHANGES.

Page 7-14 Change of Ownership or Location, Top of the Page, first paragraph: (Delete) THE DMH MUST BE NOTIFIED AT LEAST 60 DAYS PRIOR TO A CHANGE OF OWNERSHIP OR CHANGE OF ADDRESS FOR A CERTIFIED SD/MC PROGRAM. (Add) THE LOCAL MENTAL HEALTH DIRECTOR OR DESIGNEE SHALL NOTIFY THE APPROPRIATE DEPARTMENT OF MENTAL HEALTH, MEDI-CAL OVERSIGHT CHIEF (SEE PAGE 7-8) 60 DAYS PRIOR TO THE CHANGES NOTED BELOW. THE NOTIFICATION SHOULD INCLUDE THE EFFECTIVE DATE AND A DESCRIPTION OF THE CHANGES. (Delete) FAILURE TO COMPLY MAY RESULT IN A TEMPORARY DECERTIFICATION, DELAY, OR ACTUAL LOSS OF SD/MC REVENUE FOR SERVICES PROVIDED DURING THE NON-CERTIFIED PERIOD.

Page 7-14 #2 Change of Ownership or location, first sentence: change the local mental health director OF designee: (Change to read) The Local health director OR designee.

Page 7-14: (Add) #3 PLANNED STRUCTURAL CHANGES REQUIRING A NEW FIRE CLEARANCE.

Page 7-14: (Add) #4 THE PROVIDER ADDS DAY TREATMENT OR MEDICATION SUPPORT SERVICES WHEN MEDICATIONS WILL BE ADMINISTERED OR DISPENSED FROM THE PROVIDER SITE.

Page 7-16 Update service modes: (Add) PSYCHIATRIC HEALTH FACILITIES (PHF) AND EMERGENCY ROOM/URGENT CARE.

Page 7-20 "2.0" Orders For Drugs, first sentence: Change persons AWFULLY authorized to read persons LAWFULLY authorized.

Page 7-20 "2.0" Orders For Drugs: (Add a new paragraph) VERBAL ORDERS MAY BE RECEIVED BY A LICENSED PHARMACIST, LICENSED REGISTERED NURSE, LICENSED VOCATIONAL NURSE OR A LICENSED PSYCHIATRIC TECHNICIAN. VERBAL ORDERS SHALL BE RECORDED IMMEDIATELY IN THE CLIENT'S HEALTH RECORD BY THE PERSON RECEIVING THE ORDER AND SHALL INCLUDE THE DATE AND TIME ORDERED. SUCH ORDERS SHALL BE SIGNED BY A PRESCRIBER WITHIN FIVE DAYS.

PAGE 7-21 "F" moved from 7-20 to 7-21

DEFINITIONS: Chapter 8

Page 8-1 Academic Education: (Delete) FOR THE PURPOSE.

Page 8-1 Adult Crisis Residential: (Delete) CRISIS. (Delete) (SEE CRISIS RESIDENTIAL TREATMENT).

Page 8-3 Crisis Residential: (Delete) (SEE ADULT CRISIS RESIDENTIAL).

Page 8-4 Crisis Stabilization Emergency Room, second line: (Change) IN a 24 hour health facility to read AT a 24 hour health facility.

Page 8-4 Day Treatment Intensive, forth line: (Delete) IAN (Add) IN A

Page 8-6 Registered Nurse, second line: (Delete) CALIFORNIA BOARD OF NURSING EDUCATION. (Insert) CALIFORNIA BOARD OF REGISTERED NURSING.

Page 8-7 Inpatient Hospital Services, a., second line: (Delete) AN.

Page 8-9 Mental Health Rehabilitation Specialist, sixth sentence: (Change) EXPERIENCE to EDUCATIONAL EXPERIENCE (As defined in Title 9).

Page 8-12 Registered Nurse: (Delete) BOARD OF NURSING EDUCATION AND NURSE REGISTRATION IN THE STATE OF CALIFORNIA. (Insert) CALIFORNIA BOARD OF REGISTERED NURSING.

Page 8-14 Window Period: (Change to read) THE WINDOW PERIOD REFERS TO SPECIFIC TIMELINES FOR THE REVIEW AND REVISION OF THE INDIVIDUAL'S SERVICE PLANS, TREATMENT PLAN, COORDINATION PLAN, AND COMMUNITY FUNCTIONING EVALUATION. A PLAN/EVALUATION SIGNED ANY TIME DURING THE WINDOW PERIOD SHALL BE EFFECTIVE FOR THE SUBSEQUENT PERIOD. THE SPECIFIC TIMELINE FOR THE WINDOW PERIOD (TRADITIONAL QA) IS 15 DAYS PRIOR TO THE EXPIRATION OF THE CURRENT TX PLAN, SERVICE PLAN AND UR FOR THE NEXT AUTHORIZED SIX MONTH PERIOD FOR MENTAL HEALTH SERVICES OR ADULT RESIDENTIAL AND THE NEXT THREE MONTH PERIOD FOR DAY REHABILITATION SERVICE

SHORT DOYLE/ MEDI-CAL MANUAL

FOR

THE REHABILITATION OPTION

AND

TARGETED CASE MANAGEMENT

CHILDREN, ADOLESCENTS, ADULTS AND OLDER ADULTS

Systems of Care

California Department of Mental Health

(916) 654-2526

Effective: 7/1/93
Revised: 7/1/94
Revised: 7/1/95

Services for adults and older adults are based on the following values:

A system driven by the Individual: The provision of services and support should take place in the Individual's environment and be directed and determined by the Individual's needs and desires, whenever possible.

Individual empowerment: The system must focus on Individual needs, strengths, and choices and demonstrate Individual involvement in service planning and implementation. The goal is to help Individuals take charge of their lives through informed decision making.

Sensitivity to family members, care givers, and others within the Individual's support system: Families, care givers and other persons significant to the Individual need to be supported as they participate in the planning and implementation process in meeting Individual needs, choices, responsibilities, and desires. This may include assisting the Individual and his/her family in their family relationships with consideration of the Individual's (family) culture and language.

Age and gender: Each person is unique and therefore services and relationships should be based on the Individual's specific needs. The provider staff should demonstrate responsiveness to the Individual's age and gender.

Ethnicity, language, and culture: Each person is unique and therefore services and relationships should be based on the Individual's uniqueness and within the context of culture and in the preferred language of the Individual. The provider staff should demonstrate responsiveness, understanding, and respect for the Individual's culture and language and provide services in the Individual's preferred language.

Normalization: The Individual should be in the least restrictive and most natural and culturally appropriate environment which fosters independence using all community resources, not just mental health.

Individualized services: The system should foster the use of creative options that stress the concept that everyone is unique in many ways including culturally and linguistically and, at any time, has the ability to learn, grow, change, and develop.

Caring and sensitive staff: The system needs to support and advocate for staff who are caring and sensitive to gender, ethnicity, culture, and sexual orientation and who participate equally with other staff in the overall delivery of mental health services. In addition to bilingual and bicultural staff, the system recognizes that high levels of age related knowledge and skill are required for services to Individuals.

Reimbursement Rules

Key Points Applicable to All Services

The following statements apply to all services described in this document:

⇒ Provider must be certified as a Mental Health Rehabilitation Provider to be eligible for reimbursement and provide SD/MC services (except inpatient hospital services).

⇒ Contacts with significant support persons are reimbursable if they are directed exclusively to the mental health needs of the Individual. Services may be face-to-face or on the telephone, unless otherwise noted in the service definition.

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

⇒ SD/MC standards do not require the following service activities described under Mental Health Services to be separately identified in the progress notes: Collateral, Assessment, Evaluation, Therapy, Rehabilitation, and Plan Development. Counties, however, may be required to document these distinct activities in order to meet the requirements of insurance companies and other third party payers, or program management needs.

⇒ Services shall be provided within the staff person's scope of practice. The local mental health director shall be responsible for assuring that services provided are commensurate with the professionalism and experience of the staff utilized.

⇒ For counties that are implementing Coordinated Services, Coordination may be billed under Mental Health Services, Day Treatment Intensive, Day Rehabilitation, Adult Residential, Medication Support, or Case Management/Brokerage as a "plan development" service activity. Please refer to the definition of plan development listed under Mental Health Services.

⇒ Services provided to children or adolescents in a juvenile hall setting are reimbursable if the Individual has been adjudicated and is awaiting placement.

⇒ Outpatient Hospital Services operating under the license of a hospital may only provide SD/MC services in compliance with licensing requirements, per California Code of Regulations, Title 22, Section 51113.

⇒ Only Psychiatric Health Facility Services provided in facilities licensed for 16 beds and under are reimbursable for SD/MC under the Rehabilitation Option.

For Services Based on Staff Time

Mental Health Services
Medication Support Services
Crisis Intervention
Case Management/Brokerage

The following rules apply:

⇒ The exact number of minutes used by staff providing a reimbursable services shall be reported and billed. In no case shall more than 60 units of time be reported or claimed for any one staff person during a one-hour period. Also, in no case shall the units of time reported or claimed for any one staff member exceed the hours worked.

⇒ When a staff member provides service to, or on behalf of, more than one Individual at the same time, the staff member's time must be prorated to each Individual. When more than one staff person provides a service, the time utilized by all involved staff members shall be added together to yield the total billable services. The total time claimed shall not exceed the actual staff time utilized for billable services.

> **Example:** If a service is provided by two staff to a group of seven Medi-Cal eligible Individuals, and the reimbursable service, including direct service, travel time, plan development and documentation, lasts one hour and thirty-five minutes for each staff person, total units reported shall be 95 minutes times two staff divided by seven Individuals (95 min. X 2 staff) / 7 Individuals = 27.1 minutes. This would be rounded to the nearest minute, so 27 minutes would be billed for each Individual.

⇒ The time required for documentation and travel shall be linked to the delivery of the reimbursable service.

⇒ Plan development for Mental Health Services and Medication Support Services is reimbursable. Units of time may be billed when there is no unit of service (e.g., time spent in plan development activities may be billed regardless of whether there is a face-to-face or phone contact with the Individual or significant other.)

Non-Reimbursable Activities

Certain activities are clearly specified as not allowable under the Rehabilitation Option and Targeted Case Management:

- Academic educational services.
- Vocational services which have as a purpose actual work or work training.
- Recreation.
- Personal care services provided to Individuals. These include grooming, personal hygiene, assisting with medication, and the preparation of meals, when performed for the Individual.
- Socialization is not reimbursable if it consists of generalized group activities which do not provide systematic individualized feedback to the specific targeted behaviors of the Individuals involved.
- Transportation of an Individual to a service is not reimbursable by SD/MC. The transportation costs could be factored into the overall expense (rate) of providing a SD/MC service. (Refer to page 2-4, third bullet, for travel reimbursement for staff time based services.)
- Board and care costs for Adult Residential Treatment Services and Crisis Residential Treatment Services.

The setting in which an Individual resides makes services non-reimbursable through SD/MC.

- Services provided in a jail or prison setting.
- Services provided to persons aged 22 through 64 who are residents of an Institution for Mental Disease.
- Services provided to children or adolescents in a juvenile hall setting unless the Individual has been adjudicated and is awaiting placement.

Factors to Consider in Determining Whether a Service is Reimbursable:

In determining whether a given service is reimbursable under SD/MC, focus, site and remuneration are factors to be considered. Reimbursable services aid the Individual to integrate in the community, access necessary resources, and maximize interpersonal skills. Interventions which focus on skills specific to vocational training, academic education, or recreation activity are not reimbursable.

Crisis Intervention

Description:

Crisis Intervention is a quick emergency response service enabling the Individual to cope with a crisis, while maintaining his/her status as a functioning community member to the greatest extent possible. A crisis is an unplanned event that results in the Individual's need for immediate service intervention. Crisis Intervention services are limited to stabilization of the presenting emergency. This service does not include Crisis Stabilization - Emergency Room which is provided in a 24-hour health care facility or hospital outpatient program or Crisis Stabilization - Urgent Care which is provided in a certified Mental Health Rehabilitation provider site.

Service Activities:

Service activities include but are not limited to Assessment, Evaluation, Collateral, and Therapy.

Site and Contact Requirements:

Services may either be face-to-face or by telephone with the Individual or significant support persons and may be provided anywhere in the community.

Billing Unit:

The billing unit for Crisis Intervention is staff time, based on minutes of time.

Lockouts:

Crisis Intervention is not reimbursable on days when Crisis Residential Treatment Services, Psychiatric Health Facilities Services, or Inpatient Services are reimbursed, except for the day of admission to those services. The maximum amount billable for Crisis Intervention in a 24-hour period is 20 hours.

Staffing:

Commensurate with scope of practice, Crisis Intervention may be provided by any of the following staff:

- Physician
- Psychologist
- Licensed Clinical Social Worker
- Marriage, Family and Child Counselor
- Registered Nurse
- Licensed Vocational Nurse

Crisis Stabilization - Emergency Room

Description:

This is an immediate face-to-face response lasting less than 24 hours, to or on behalf of an Individual exhibiting acute psychiatric symptoms, provided in a 24 hour health facility or hospital based outpatient program. The goal is to avoid the need for Inpatient Services by alleviating problems and symptoms which, if not treated, present an imminent threat to the Individual or other's safety or substantially increase the risk of the Individual becoming gravely disabled. Services provided to Individuals in a Crisis Stabilization - Emergency Room program must be separate and distinct from services provided to Individuals in an Inpatient facility or 24 hour health care facility. Services shall be available 24 hours per day.

Service Activities:

Service activities are provided as a package and include but are not limited to Crisis Intervention, Assessment, Evaluation, Collateral, Medication Support Services, and Therapy.

Site and Contact Requirements:

1) Crisis Stabilization - Emergency Room shall be provided at a licensed 24 hour health care facility, including psychiatric health facilities, or hospital based outpatient programs.

2) Emergency medical backup services must be available either on site or by written contract or agreement with a hospital. Emergency medical backup means immediate access within reasonable proximity to health care for medical emergencies. Immediate access and reasonable proximity shall be defined on a county by county basis. Medications must be available on a PRN basis and the staffing pattern must reflect this availability.

3) Service may not be provided off-site.

4) All Individuals receiving Crisis Stabilization - Emergency Room shall receive an assessment of their physical and mental health. This may be accomplished by protocols approved by a physician. If outside services are needed, a referral which corresponds with the Individual's need shall be made to the extent resources are available.

Billing Unit:

The billing unit for Crisis Stabilization - Emergency Room is client time, based on one hour blocks of time the Individual (client) receives SD/MC services in the program. Partial blocks of time shall be rounded up or down to the nearest one hour increment with the exception of services lasting less than one hour, which shall always be rounded up to a one hour increment.

Lockouts:

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

Crisis Stabilization - Emergency Room is a package program and no other SD/MC services are reimbursable during the same time period this service is reimbursed, except for Case Management/Brokerage.

> **NOTE:** The maximum number of hours billable for Crisis Stabilization - Emergency Room, in a 24-hour period, is 20 hours.

Staffing:

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

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

3) At a minimum there shall be a ratio of at least one of the following licensed staff on site for each four Individuals (1:4) receiving Crisis Stabilization - Emergency Room services at any given time:

   - Physician
   - Psychologist
   - Licensed Clinical Social Worker
   - Marriage, Family and Child Counselor
   - Registered Nurse
   - Licensed Vocational Nurse
   - Psychiatric Technician

> **NOTE:** Clinical Social Worker, Psychologist, and Marriage, Family and Child Counselor candidates with waivers are considered as licensed and are included in these staff categories.

4) If the Individual is evaluated as needing service activities that can only be provided by an LPHA, such staff shall be available.

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

Lockouts:

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

Crisis Stabilization - Urgent Care is a package program and no other SD/MC services are reimbursable during the same time period this service is reimbursed, except for Case Management/Brokerage.

> **NOTE:** The maximum number of hours billable for Crisis Stabilization - Urgent Care, in a 24-hour period, is 20 hours.

Staffing:

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

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

3) At a minimum there shall be a ratio of at least one of the following licensed staff on site for each four Individuals (1:4) receiving Crisis Stabilization - Urgent Care services at any given time:

   - Physician
   - Psychologist
   - Licensed Clinical Social Worker
   - Marriage, Family and Child Counselor
   - Registered Nurse
   - Licensed Vocational Nurse
   - Psychiatric Technician

> **NOTE:** Clinical social worker, Psychologist, and Marriage, Family and Child Counselor candidates with waivers are considered as licensed and are included in these staff categories.

4) If the Individual is evaluated as needing service activities that can only be provided by an LPHA, such staff shall be available.

Lockouts:

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

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

Staffing Ratios:

Staffing ratios in Psychiatric Health Facility Services shall be consistent with Section 77061 of Title 22, CCR.

Staffing qualifications shall be consistent with Sections 77004, 77011.2, 77012, 77012.1, 77012.2, 77014, 77017, 77023, 77059-77069, 77079.1 and 77079.12 of Title 22, CCR.

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

Targeted Case Management/Brokerage

Description:

Case Management/Brokerage services are activities provided by program staff to access medical, educational, social, prevocational, vocational, rehabilitative, or other needed community services for eligible Individuals.

Service activities:

> **NOTE:** Not all of the activities need to be provided for a service to be billable.

LINKAGE AND CONSULTATION - The identification and pursuit of resources including but not limited to, the following:

- Interagency and intra-agency consultation, communication, coordination, and referral.
- Monitoring service delivery to ensure an Individual's access to service and the service delivery system.
- Monitoring of the Individual's progress
- Plan Development

PLACEMENT SERVICES - Supportive assistance to the Individual in the assessment, determination of need and securing of adequate and appropriate living arrangements, including, but not limited to the following:

- Locating and securing an appropriate living environment.
- Locating and securing funding.
- Preplacement visit(s)
- Negotiation of housing or placement contracts.
- Placement and placement follow-up.
- Accessing services necessary to secure placement.

> **NOTE:** Case Management/Brokerage is not skill development, assistance in daily living, or training an Individual to access services him/herself. (See Mental Health Services.)

Comparison of Case Management Under the Clinic and Rehabilitation Option

According to the Health Financing Administration (HCFA), "While case management-type services directed at managing Medicaid covered services may be a covered component of rehabilitation services, case management services which are directed toward gaining access to and monitoring non-Medicaid services are not reimbursable under the rehabilitation option. The latter services may be covered under the separate case management benefit option." Since this federal description of the Rehabilitation Option does not allow us to bill services designed to gain access to non-Medicaid services, California has chosen to include linkage to both Medicaid and non-Medicaid services under a Case Management/Brokerage service function. Therefore, Case Management/Brokerage is billed as a Targeted Case Management service function, rather than a Rehabilitation Option service function. Other service activities identified as Case Management activities in DMH Letter No. 92-07 will now be billed under the Rehabilitation Option, as Mental Health Services.

Case Management Activity	Rehab Option Service
Evaluation or reevaluation	Mental Health Services
Plan Development	Mental Health Services
Linkage and Consultation	Case Management/Brokerage
Placement Services	Case Management/Brokerage
Assistance with Daily Living	Mental Health Services
Emergency Intervention	Crisis Intervention

* Please note that other services, including Day Treatment Intensive, Day Rehabilitation, Medication Support Services, Case Managment/Brokerage and Adult Residential Services, will also include plan development as part of those reimbursed services.

LOCKOUTS, OVERRIDES, COMPUTER EDITS, & OTHER LIMITATIONS

	MII Svc	Med Supp*	CM Brkrge	DTI Full Day	DTI ½ Day	Day Rehab Full Day	Day Rehab ½ Day	Adult Res Tx	Crisis Res Tx	Crisis Intvntn**	Crisis Stab ER&UC***	Inpatient	PHF
MII Services				T	T	T	T		A		T	A	A
Med Support*											T	A	A
CM/Brokerage												I	
DT Intensive Full Day	T			L	L	L	L		A		T	A	A
DT IntensiveHalf Day	T			L	L	L	OR		A		T	A	A
DT Rehab Full Day	T			L	L	L	L		A		T	A	A
DT Rehab Half Day	T			L	OR	L	L		A		T	A	A
Adult Residential Tx								L	L		T	A	A
Crisis Residential Tx	A			A	A	A	A	L	L	A	T	A	A
Crisis Intervention**									A		T	A	A
Crisis Stab ER & UC ***	T	T		T	T	T	T	T	T	T	T	A	A
Inpatient	A	A	I	A	A	A	A	A	A	A	A	L	A
PHF	A	A		A	A	A	A	A	A	A	A	L	A

Notes: I= Institutional Limitations-Audit
L=Lockout OR=Override
A=Lockout except for day of admission
T=Lockout during actual time service is provided-audit, not a computer edit
Providers may not allocate the same staff time under two cost centers for the same time period

*Maximum of 4 hours per day **Maximum per 24 hour period is $1,234 ***Maximum per 24 hour period is 20 hours

Medication Monitoring

Function:

To establish a process to ensure the appropriate use and management of psychotropic and other medications. Systematic monitoring is intended to:

1. Increase the effective use of psychotropic medication;

2. Reduce the inappropriate use of medications and the likelihood of the occurrence of adverse effects;

3. Improve knowledge of service delivery staff in psychotropic medication use;

4. Encourage education of Individuals about psychotropic medications and the role of medication in community functioning; and

5. To ensure that informed consent (Welfare and Institutions Code [WIC], Section 5326.2), appropriate use of emergency medication and/or Riese Hearing (WIC, Section 5332) is documented.

Requirements:

Ongoing screening for compliance with acceptable screening criteria of a sample of SD/MC charts/prescriptions where medication services or prescriptions have been provided.

1. The minimum sample size is to be determined by the local mental health director. (Sample size must be at least five percent [5%] annually.)

2. Refer charts where there are concerns regarding medication support services to the Quality Improvement Committee.

Minimum Documentation:

1. Document activities and results of medication monitoring.

2. Referrals to the Quality Improvement Committee.

3. Documentation must be made available to the state upon request.

4. Role and qualifications of persons assigned responsibility for medication monitoring:

   A. The medication monitoring function shall be in conjunction with or under the supervision of a person licensed to prescribe or dispense prescription drugs.

   B. The registered nurse's role in medication monitoring is under the supervision of a physician or pharmacist.

♦ **Dated Signature(s):**
Medication Reviewer (chart review and referrals)

Frequency:

⇒ Continuous reviews and referrals

COMPARISON OF QUALITY ASSURANCE STANDARDS

REQUIREMENTS	OLD QA (DMH 89-20, 92-07)		NEW TRADITIONAL QA		COORDINATED SERVICES
Coordination of Services	No		No		Coordinator, Countywide Plan
Admission Period (maximum time before approval required to complete Treatment or Service Plan)	5 visits or 30 days whichever comes first		15 units or 30 days whichever comes first 72 hours for Crisis Resedential Treatment		2 months to complete Coordination Plan Service Plan(s) by end of admission or within one month of first service contact (72 hours for Crisis Residential)
Approval of Services	Initial	Max Auth for	Initial	Max Auth for	Coordination Plan
Type and Provider	Approval Needed	Extended Svc	Approval Needed	Extended Svc	By Coordinator (LPHA)
Mental Health Services	>12 visits	24 visits	>24 visits	24 units	12 months
Medication Support	NA	NA	NA	NA	12 months if Med Support provided in addition to other services requiring a Coordination Plan
Case Management/Brokerage	>30 days**	6 months	NA	NA	NA
Day Rehabilitation	>15 visits*	3 months	>15 units*	3 months	12 months
Day Treatment Intensive	>15 visits	30 visits	>15 units*	30 units	12 months
Crisis Intervention	Included with Mental Health Services		NA	NA	NA
Crisis Residential Treatment			72 hours*	14 units	NA
Adult Residential Treatment	* By Utilization Review Committee		15 units*	6 months	12 months
Crisis Stabilization ER & UR	**By Utilization Review Committee or Coordinator		NA	NA	NA
Psychiatric Health Facility Service			NA	NA	NA
			*By Utilization Review Committee		
Service Plan Duration					
Mental Health Services	6 months		Tx Plan or Svc Plan: 6 months		6 months
Medication Support	6 months		Tx Plan: 6 months		In Med Progress Notes
Case Management/Brokerage	6 months		NA		NA
Day Rehabilitation	6 months		Tx Plan: 6 months		6 months
Day Treatment Intensive	6 months		Tx Plan: 6 months		6 months
Crisis Intervention	6 months		NA		NA
Crisis Residential Treatment	NA		Tx Plan: 6 months		6 months
Adult Residential Treatment	NA		Tx Plan: 6 months		6 months
Crisis Stabilization ER & UC	NA		NA		NA
Psychiatric Health Facility Services	NA		NA		NA

NOTE: LPHA= MD; Ph.D.; LCSW; MFCC; or Registered Nurse UNIT= Face to face or phone contact with individual

COMPARISON OF QUALITY ASSURANCE STANDARDS

OLD QA, NEW TRADITIONAL QA, AND QUALITY MANAGEMENT

REQUIREMENTS	OLD QA (DMH 89-20, 92-07)	NEW TRADITIONAL QA	COORDINATED SERVICES
Plan Approval: EVERY 6 MONTHS			
Mental Health Services	Physician	LPHA/LCM	*Coordinator
Medication Support	Physician	Physician	NA
Case Management/Brokerage	LCM	NA	NA
Day Rehabilitation	Physician	LPHA	*Coordinator
Day Treatment Intensive	Physician	LPHA	*Coordinator
Crisis Intervention	Physician	NA	NA
Crisis Residential Treatment		LPHA	NA
Adult Residential Treatment		LPHA	*Coordinator
Crisis Stabilization ER & UR		NA	NA
Psychiatric Health Facility Service		NA	NA
Evaluation		Annual community functioning evaluation by Mental Health Services providers	One annual community functioning evaluation
Billable Services	**Outpatient** Collateral Assessment Individual Group **Medication** **Case Management** **Day Care Habilitative** **Day Care Intensive** **Crisis**	Mental Health Services Medication Support Case Management/Brokerage Day Rehabilitation Day Treatment Intensive Crisis Intervention Crisis Residential Treatment Adult Residential Treatment Crisis Stabilization ER & UR Psychiatric Health Facility Service	Mental Health Services Medication Support Case Management/Brokerage Day Rehabilitation Day Treatment Intensive Crisis Intervention Crisis Residential Treatment Adult Residential Treatment Crisis Stabilization ER & UR Psychiatric Health Facility Service
Medical/Service Necessity Documentation	Ongoing	Ongoing	At intake, update as needed, and annually

* Service Plans without changes do not require the Coordinator's approval for 6 month updates. Annually, the Coordinator must approve all Service Plans

COMPARISON OF QUALITY ASSURANCE STANDARDS

OLD QA, NEW TRADITIONAL QA, AND QUALITY MANAGEMENT

REQUIREMENTS	OLD QA (DMH 89-20, 92-07)		NEW TRADITIONAL QA		COORDINATED SERVICES
UR Requirements	**Init. Review**	**Subseq. Review**	**Init. Review**	**Subseq. Review**	**Systemwide**
Mental Health Services	>12 visits	24 units	>24 units	24 units	County selects sample of high cost users, all SD/MC providers, and all populations. A 5% minimum sample size of unduplicated cases open after the Intake Period
Medication Support	NA	NA	NA	NA	
Case Management/Brokerage	>30 days	6 months	NA	NA	
Day Rehabilitation	>15 days	3 months	15 units	3 months	
Day Treatment Intensive	>15 days	30 visits	15 units	30 units	
Crisis Intervention	included in Mental Health Services		NA	NA	
Crisis Residential Treatment			72 hours	14 units	
Adult Residential Treatment			15 units	6 months	
Crisis Stabilization			NA	NA	
	Completed at time of approval of services		Completed at time of approval of services		
State UR	10 individual records biannually		At least 10 individual records per provider biannually with increased frequency/charts for high disallowance		1% of cases: all SD/MC services annually after Intake Period with increased frequency/cases for high disallowance
Medication Progress Notes	Side effects, response to medications, and compliance in each note.		Side effects, response to medications, and compliance in each note.		Plan for service, side effects, response, and compliance documented when change occurs
Window Period	15 days-UR ; Service Plan & Tx Plan		15 days-UR ; Service Plan & Tx Plan		1 month
Focus of Review	Medical/Service Necessity Compliance with documentation Level of service/need		Medical/Service Necessity Compliance with documentation Level of service/need		Medical/Service Necessity Compliance with documentation Quality Improvement
Order of Progress Notes	Case Management sections separate		Mental Health Services and Case Management sections separate		All progress notes may be in one section in chronological order
Committees	Utilization Review Committee & Peer Review		Utilization Review Committee		Quality Improvement Committee

Community Functioning Evaluation

Minimum Documentation Requirements:

- Status of Individual's community functioning or statement of Individual's substantial impairment in the four target areas:

  Living Arrangements
  Daily Activities
  Social Relationships
  Health

- **Dated Signature(s):**

  Within county scope of practice guidelines, service delivery staff completing or participating in the evaluation.

Frequency:

⇒ By the end of the Intake Period for Individuals who will receive ongoing services including Medication Support Services and/or Case Management/Brokerage.

⇒ Annually updated according to the Month of Intake Schedule. The Window Period applies to the Annual Update.

⇒ For individuals receiving Medication Support only, the Community Functioning Evaluation may be documented in the Progress Notes.

- **Dated Signature(s):**

  Coordinator
  Individual (or date of a statement in the Progress Notes of why no signature was obtained)
  Family or Significant Support Person (if requested by Individual)
  Licensed Practitioner of the Healing Arts (if the Coordinator does not meet the qualifications)

Frequency:

⇒ By the end of the Intake Period for the Individual receiving ongoing Mental Health Services, Day Treatment Intensive, Day Rehabilitation and Adult Residential services.

⇒ By the end of the Intake Period for the Individual receiving ongoing Medication Support in addition to one or more of the above mentioned services.

⇒ After the Intake Period, within one month of the first contact with Mental Health Services, Day Treatment Intensive, Day Rehabilitation, Adult and Residential and Medication Support when provided in addition to one or more of these services.

⇒ Whenever new Mental Health Services, Day Treatment Intensive Services, Day Rehabilitation Services, and/or Adult Residential Services are started for the Individual, the Coordination Plan shall be updated within one (1) month of the date of the first service unit (contact) provided to the Individual.

⇒ Whenever Medication Support Services are started for an Individual presently receiving Mental Health Services, Day Treatment Intensive, Day Rehabilitation, and/or Adult Residential Services, the Coordination Plan shall be updated within one month of the date of the first Medication Support Services contact.

⇒ Annually according to the Month of Intake Schedule. The Window Period applies to the Annual Rewrite.

NOTE: Services are authorized for the specified duration or until the Personal Milestones are achieved - whichever comes first.

NOTE: The Coordination Plan requirements must be met when billing for planned SD/MC services, even in cases where:

1) **the Individual is retroactively determined to be eligible for Medi-Cal,**
2) **Medicare or other health insurance programs denied payment of a claim for services, or**
3) **Individuals do not identify themselves as a Medi-Cal beneficiary.**

Service Plan

Minimum Documentation Requirements for Mental Health Services, Day Treatment Intensive, Day Rehabilitation and Adult Residential Services:

Service Plan is not required for the Coordinator to provide Coordination Related Activities.

Service Plan is also required for Crisis Residential Treatment Services which exceed 72 hours. The Crisis Residential Service Plan does not require Coordinator Approval.

- Personal Milestone(s): Targets for the Individual and the Service Delivery staff towards achieving the Desired Result. They may focus on the four areas of Community Functioning:

  Living Arrangement
  Daily Activities
  Social Supports
  Health

  Personal Milestones should specify observable behaviors to ensure that staff and coordinators can determine when a milestone has been achieved.

- Obstacle(s) to meeting Personal Milestone(s).

- Individual's Activities (or statement of why the Individual's Activities are not specified).

- Family or Support Person's Activities (as applicable).

- Service Delivery Staff's Activities.

- Date of Coordinator's verbal or written approval.

♦Dated Signature(s):

Individual (or a statement in the progress notes of why the Individual's signature is not present)
Family or Significant Support Person (as applicable)
Service Delivery Staff
Qualified Mental Health Professional (if service delivery staff does not meet the qualifications)

Frequency:

⇒ By the end of the Intake Period or within one month of initial planned service contact (whichever is later) for Mental Health Services, Day Treatment Intensive, Day Rehabilitation and Adult Residential Services.

⇒ Within 72 hours of admission to Crisis Residential Treatment Services.

⇒ Updated every six months and rewritten annually according to the Month of Intake Schedule or when the Service Plan expires (whichever comes first). Six month updates with no changes do not require Coordinator approval. The Window Period applies to the six month updates and the annual rewrite.

NOTE: Only one service plan is required per provider for Mental Health Services, Day Treatment Intensive, Day Rehabilitation or Adult Residential Services. Medication Support Services plans for services may be documented in the Progress Notes rather than a separate document.

NOTE: Services are authorized for the specified duration or until the Personal Milestones are achieved - whichever comes first.

NOTE: Case Management/Brokerage Services do not require either a Service Plan or a Plan for Service.

Progress Notes - Planned Services

Intake Period:

Progress notes are a description of what was attempted or accomplished at the time the service was delivered. Intake Period, Progress Notes must document the presenting problem, the plan for subsequent service, and reason to believe the Individual meets medical/service necessity. This information is not required for every progress note, but must reflect new information or changes as they occur. Intake progress notes must include the Date of Service, Service Function, Location of Service, and Duration of Service for time based services. For specific types of services, follow the minimum documentation requirements for that type of service.

Mental Health Services (after Intake Period):

Minimum Documentation Requirements:

- Date of Service
- Service Function (Identify Type of Service delivered)
- Location of Service
- Duration of Service
- A description of what was attempted and/or accomplished by the Individual, family (when applicable), and service staff toward the Personal Milestones, or what was necessary at the time the service was delivered
- Description of changes in Individual's medical necessity

Signatures:

- A Person(s) who delivers the services.

Co-Signature Requirements:

Within county scope of practice guidelines, Mental Health Services provided by unlicensed staff without a Bachelor's Degree in a mental health related field or two years of experience delivering mental health services must have all progress notes co-signed by one of the following professional staff , until the experience/education requirement is met.

- Physician
- Psychologist
- Licensed Clinical Social Worker
- Marriage, Family and Child Counselor
- Registered Nurse
- Licensed Vocational Nurse
- Psychiatric Technician
- Mental Health Rehabilitation Specialist

UTILIZATION REVIEW CONTROL REQUIREMENTS

SD/MC Rehabilitation Services shall be reviewed by the UR/URC on a concurrent and ongoing basis. Continued approval depends upon the documentation of medical necessity, appropriateness of the level of care, and frequency of services.

UNIT OF SERVICE: Units are a means of measuring the volume of service provided, such as a contact, a visit, or a day.

Mental Health Services:

Initial Units:

Within the initial six-month period, URC approval must be obtained prior to the 25th unit of service. URC authorization shall be for a maximum of 24 units of service. For children's services, an additional 24 units of service for contacts with significant others may be granted.

Exempt Units:

Within a fixed six-month period, 24 units of service may be provided without prior approval by a URC. (All initial six-month periods for Rehabilitation Services begin on the first day of the month of admission to that service function.) The specified maximum units of service (24) in a six-month period may continue without prior URC review for as long as medically necessary. Counties or providers may set shorter review requirements at their discretion.

Extended Units:

The URC has the authority to approve extended units of service. Prior to the end of the previously authorized units of service in a six-month period, the URC may, after review of appropriate clinical justification in the Individual record or resume, authorize up to a maximum of 24 additional units of service which shall be valid only during the current six-month period. For children's services, an additional 24 units of service, for contacts with significant others may be granted. The URC may authorize additional increments of up to a specified number of units of service as needed within the six-month period. Extended units of service, during the current period, are effective on the date the URC meets and approves the request.

Extended services for the next six-months may be authorized no earlier than 15 days prior to the beginning of the period without invalidating authorized units of service remaining in the current six-month period. Approved units of service for the next six-month period must be identified as such by the URC. Unused approved units of service cannot be carried over to the next six-month period.

Prior Approval:

The need for prior approval by the URC relative to the initial units of service in a new six-month period is determined by the number of units of service in the preceding period. URC action is required if more than 24 units of service occurred during the preceding six-month period.

Day Treatment Intensive:

Initial Units:

The initial URC approval must be obtained prior to the 16th unit of service. URC authorization shall be for a maximum of 30 unit increments.

Extended Units:

The URC has the authority to approve extended units of service. Prior to the last day of the previously approved units of service, the URC may, after review of appropriate clinical justification in the Individual record or resume, authorize up to a maximum of 30 additional units of service. These extended units are effective on the date the URC meets and approves the request.

Prior Approval:

Prior approval for this service function is always needed for extended units of service.

Day Rehabilitation:

Initial Units:

The initial URC approval must be obtained prior to the 16th unit of service. URC authorization shall be a maximum of three month increments.

Extended Units:

The URC has the authority to approve extended units of service. Prior to the end of the previously authorized time period, the URC may, after review of appropriate clinical justification in the Individual record or resume, authorize up to a maximum of three additional months.

Extended unitis of service may be authorized no earlier than 15 days prior to the beginning of the next authorized period without invalidating the authorized units of services remaining. Approved units of service for the next period must be identified as such by the URC.

Prior Approval:

Prior approval for this service function is always needed for extended units of service.

Adult Residential Treatment:

Initial Units:

URC approval must be obtained prior to the 16th unit of service. URC authorization shall be for a maximum of six-month increments.

Extended Units:

The URC has the authority to approve extended units of service. Prior to the end of the previously authorized time period, the URC may, after review of appropriate clinical justification in the Individual record or resume, authorize up to a maximum of six additional months.

Extended units of service may be authorized no earlier than 15 days prior to the beginning of the next authorized period without invalidating the authorized units of services remaining. Approved units for the next period must be identified as such by the URC.

Prior Approval:

Prior approval for this service function is always needed for extended units of service.

Crisis Residential:

Initial Units:

URC approval must be obtained prior to the end of the first 72 hours of admission. URC authorization shall be for a maximum of 14 unit increments.

Extended Units:

The URC has the authority to approve extended units of service. Prior to the end of the previously authorized time period, the URC may, after review of appropriate clinical justification in the Individual record or resume, authorize up to a maximum of 14 units of service. Extended units of service are effective on the date the URC meets and approves the request.

Prior Approval:

Prior approval for this service function is always needed for extended units of service.

Request for URC Action:

The Individual's record or resume submitted to the URC shall include:

- Adequate description of current symptomatology and/or behavior supportive of the diagnostic impression and an indication of need for further services.

- Progress notes must be related to the diagnosis, signs and symptom, established goals and expressed in terms of changes in the functioning of the Individual. If there has been little progress, a clear explanation of the limited progress must be included. The progress notes must be reflective of the services provided.

Notification of URC Action:

The service delivery staff requesting URC action shall be notified of the URC determination.

Case Management/Brokerage:

Case Management/Brokerage does not require URC authorization.

Appeals:

Appeals of any UR Coordinator or URC decision may be made to the LMHD (or his/her designee) who shall make the final decision in the matter. Resolution of appeals must be validated, documented, and maintained as described for record keeping requirements.

Confidentiality:

Each UR Coordinator and URC must keep all records confidential and shall disclose minutes only in accordance with applicable state laws.

(See pages 5-16 through 5-18 of the manual for grid on "comparison of QA standards.")

COMPARISON OF QUALITY ASSURANCE STANDARDS

REQUIREMENTS	OLD QA (DMH 89-20, 92-07)		NEW TRADITIONAL QA		COORDINATED SERVICES
Coordination of Services	No		No		Coordinator, Countywide Plan
Admission Period (maximum time before approval required to complete Treatment or Service Plan)	5 visits or 30 days whichever comes first		15 units or 30 days whichever comes first 72 hours for Crisis Resedential Treatment		2 months to complete Coordination Plan Service Plan(s) by end of admission or within one month of first service contact (72 hours for Crisis Residential)
Approval of Services	Initial	Max Auth for	Initial	Max Auth for	Coordination Plan
Type and Provider	Approval Needed	Extended Svc	Approval Needed	Extended Svc	By Coordinator (LPHA)
Mental Health Services	>12 visits	24 visits	>24 visits	24 units	12 months
Medication Support	NA	NA	NA	NA	12 months if Med Support provided in addition to other services requiring a Coordination Plan
Case Management/Brokerage	>30 days**	6 months	NA	NA	NA
Day Rehabilitation	>15 visits*	3 months	>15 units*	3 months	12 months
Day Treatment Intensive	>15 visits	30 visits	>15 units*	30 units	12 months
Crisis Intervention	Included with Mental Health Services		NA	NA	NA
Crisis Residential Treatment			72 hours*	14 units	NA
Adult Residential Treatment	* By Utilization Review Committee		15 units*	6 months	12 months
Crisis Stabilization ER & UR	**By Utilization Review Committee or Coordinator		NA	NA	NA
Psychiatric Health Facility Service			NA	NA	NA
			*By Utilization Review Committee		
Service Plan Duration					
Mental Health Services	6 months		Tx Plan or Svc Plan: 6 months		6 months
Medication Support	6 months		Tx Plan: 6 months		In Med Progress Notes
Case Management/Brokerage	6 months		NA		NA
Day Rehabilitation	6 months		Tx Plan: 6 months		6 months
Day Treatment Intensive	6 months		Tx Plan: 6 months		6 months
Crisis Intervention	6 months		NA		NA
Crisis Residential Treatment	NA		Tx Plan: 6 months		6 months
Adult Residential Treatment	NA		Tx Plan: 6 months		6 months
Crisis Stabilization ER & UC	NA		NA		NA
Psychiatric Health Facility Services	NA		NA		NA

NOTE: LPHA= MD; Ph.D.; LCSW; MFCC; or Registered Nurse UNIT= Face to face or phone contact with individual

COMPARISON OF QUALITY ASSURANCE STANDARDS

OLD QA, NEW TRADITIONAL QA, AND QUALITY MANAGEMENT

REQUIREMENTS	OLD QA (DMH 89-20, 92-07)	NEW TRADITIONAL QA	COORDINATED SERVICES
Plan Approval: EVERY 6 MONTHS			
Mental Health Services	Physician	LPHA/LCM	*Coordinator
Medication Support	Physician	Physician	NA
Case Management/Brokerage	LCM	NA	NA
Day Rehabilitation	Physician	LPHA	*Coordinator
Day Treatment Intensive	Physician	LPHA	*Coordinator
Crisis Intervention	Physician	NA	NA
Crisis Residential Treatment		LPHA	NA
Adult Residential Treatment		LPHA	*Coordinator
Crisis Stabilization ER & UR		NA	NA
Psychiatric Health Facility Service		NA	NA
Evaluation		Annual community functioning evaluation by Mental Health Services providers	One annual community functioning evaluation
Billable Services	**Outpatient** Collateral Assessment Individual Group **Medication** **Case Management** **Day Care Habilitative** **Day Care Intensive** **Crisis**	Mental Health Services Medication Support Case Management/Brokerage Day Rehabilitation Day Treatment Intensive Crisis Intervention Crisis Residential Treatment Adult Residential Treatment Crisis Stabilization ER & UR Psychiatric Health Facility Service	Mental Health Services Medication Support Case Management/Brokerage Day Rehabilitation Day Treatment Intensive Crisis Intervention Crisis Residential Treatment Adult Residential Treatment Crisis Stabilization ER & UR Psychiatric Health Facility Service
Medical/Service Necessity Documentation	Ongoing	Ongoing	At intake, update as needed, and annually

* Service Plans without changes do not require the Coordinator's approval for 6 month updates. Annually, the Coordinator must approve all Service Plans

COMPARISON OF QUALITY ASSURANCE STANDARDS

OLD QA, NEW TRADITIONAL QA, AND QUALITY MANAGEMENT

REQUIREMENTS	OLD QA (DMH 89-20, 92-07)		NEW TRADITIONAL QA		COORDINATED SERVICES
UR Requirements	**Init. Review**	**Subseq. Review**	**Init. Review**	**Subseq. Review**	**Systemwide**
Mental Health Services	>12 visits	24 units	>24 units	24 units	County selects sample of high cost users, all SD/MC providers, and all populations. A 5% minimum sample size of unduplicated cases open after the Intake Period
Medication Support	NA	NA	NA	NA	
Case Management/Brokerage	>30 days	6 months	NA	NA	
Day Rehabilitation	>15 days	3 months	15 units	3 months	
Day Treatment Intensive	>15 days	30 visits	15 units	30 units	
Crisis Intervention	included in Mental Health Services		NA	NA	
Crisis Residential Treatment			72 hours	14 units	
Adult Residential Treatment			15 units	6 months	
Crisis Stabilization			NA	NA	
	Completed at time of approval of services		Completed at time of approval of services		
State UR	10 individual records biannually		At least 10 individual records per provider biannually with increased frequency/charts for high disallowance		1% of cases: all SD/MC services annually after Intake Period with increased frequency/cases for high disallowance
Medication Progress Notes	Side effects, response to medications, and compliance in each note.		Side effects, response to medications, and compliance in each note.		Plan for service, side effects, response, and compliance documented when change occurs
Window Period	15 days-UR; Service Plan & Tx Plan		15 days-UR; Service Plan & Tx Plan		1 month
Focus of Review	Medical/Service Necessity Compliance with documentation Level of service/need		Medical/Service Necessity Compliance with documentation Level of service/need		Medical/Service Necessity Compliance with documentation Quality Improvement
Order of Progress Notes	Case Management sections separate		Mental Health Services and Case Management sections separate		All progress notes may be in one section in chronological order
Committees	Utilization Review Committee & Peer Review		Utilization Review Committee		Quality Improvement Committee

PLANS

All SD/MC eligible Individuals must have either a Treatment Plan or Service Plan completed within 30 calendar days or 15 units of service (whichever comes first). For Crisis Residential Treatment, the Treatment Plan must be completed within 72 hours of admission. The Treatment Plan/Service Plan must be updated every six months for the following planned services:

Mental Health Services	Treatment Plan or Service Plan
Medication Support Services	Treatment Plan
Day Rehabilitation	Treatment Plan
Day Treatment Intensive	Treatment Plan
Adult Residential Treatment	Treatment Plan
Crisis Residential	Treatment Plan

Treatment Plan:

A Treatment Plan shall be a comprehensive plan of care which consists of the following components:

- A 5-Axis DSM III-R diagnosis
- Signs and symptoms of psychiatric impairment
- Specific treatment interventions and services
- Long and short-term goals
- Measurable objectives with time frames
- Estimated duration of treatment
- Prognosis
- Professional discipline responsible for each element of care
- Tentative discharge plan
- Dated legible signature of a Licensed Practitioner of the Healing Arts (LPHA)
- A dated M.D. signature is needed for Medication Support Services
- Specified drug regimen, or indication that there is no drug regimen

A Treatment Plan shall be signed and dated within 30 calendar days or 15 units of the commencement of billable SD/MC services and updated at least every six months or when there is a change in the Individual's status. For Crisis Residential Treatment, the Treatment Plan must be completed within 72 hours of admission.

The signatures of the M.D. or LPHA may be dated up to 15 calendar days prior to the expiration of the current plan. The effective date for the next six-month period must be specified.

Definitions

Legal Entity:

A county or city mental health department or agency, or a corporation, partnership, agency or individual practitioner providing public mental health services under contract with the county or city mental health department or agency.

Provider:

A specific site or group of sites (including satellites) owned, leased or operated by a legal entity, and utilized to provide SD/MC services.

A provider is assigned its own unique provider number and enters into a provider agreement with the Department of Health Services.

Satellite Site:

A site which is owned, leased or operated by a legal entity where SD/MC services are delivered for less than 20 hours per week on separate premises from the provider, but which remains under the administrative direction and professional supervision of the provider.

A satellite is not assigned a unique provider number and must be part of the same legal entity as the provider. In order to receive initial certification for the SD/MC program, a satellite must meet all fire safety requirements specified in this document under "General Requirements." At the discretion of the Department of Mental Health (DMH), a satellite may be subject to an on-site inspection. Claims for SD/MC reimbursement for services delivered by the satellite are included with the claim submitted by the provider.

When requesting certification of a provider with a satellite, the local mental health director or designee must confirm that the provider exercises direction and professional supervision of the satellite.

Public School Site:

A public school site where SD/MC services are provided may or may not be assigned its own unique provider number or be classified as a satellite site. This is at the discretion of the legal entity, regardless of the number of hours services are delivered. Fire safety requirements for public school sites are described under General Requirements.

The mental health program operating at the public school site must be a part of a provider that exercises direction and professional supervision over the school site. Staffing ratios for Day Treatment Intensive and Day Rehabilitation Services must be consistent with certification requirements identified under Program Requirements. The provider must identify its school sites at the time of the certification review. At the discretion of the DMH, a school site may be subject to an on-site inspection. A written program narrative, including the Day Treatment Intensive or Day Rehabilitation Services, is to be on file at the provider site. The narrative may include the type of program, objectives, location, days and hours of operation, services provided, staff assigned by discipline, target population, program capacity, admission and discharge criteria and any unique components.

SD/MC Provider Certification:

Upon successful completion of an on-site review by Medi-Cal Oversight staff, the DMH will provide written confirmation of the provider's compliance with all requirements for participation in the SD/MC program. The provider certification will be in force for a period of two years from the date of the site review.

Social Rehabilitation Facility/Program Certification:

As a precondition to SD/MC provider certification, a Social Rehabilitation Facility (Community Residential Treatment Program) must be certified as a social rehabilitation program by the DMH, Licensing and Certification Unit, pursuant to Title 9 regulations. It must also be licensed for 16 beds or less. (Refer to pages 7-8 and 7-9.)

Psychiatric Health Facility (PHF)/Program Certification:

As a precondition to SD/MC provider certification, a Psychiatric Health Facility (PHF), with a bed capacity of 16 or less, must be licensed as a psychiatric health facility by the DMH, Licensing and Certification Unit.

General Requirements

A provider must meet all of the following requirements before applying for SD/MC certification.

Fire Safety:

Space owned, leased or operated by providers, including satellites, and used for services or staff shall meet local fire codes. Documentation of fire safety inspections and corrections of any deficiencies shall be made available to certification reviewers upon request.

All providers seeking certification for services at public school sites must conform to school fire safety rules and regulations under the Education Code. Providers need not have available fire safety inspections and corrections for buildings owned by public schools.

Use Permits:

Approval, when necessary, shall be secured from the local agency authorized to provide a building use permit.

Physical Plant:

The physical plant of certified site owned, occupied or leased by providers shall be clean, sanitary and in good repair. Maintenance policies shall be established and implemented to ensure the safety and well-being of individuals and staff.

Administrative Policies:

Administrative policies shall be written and implemented, and shall address the following:

- personnel policies and records
- individuals' charts
- general operating procedures
- service delivery policies
- reporting of unusual occurrences relating to health and safety issues

Policies shall be in accordance with state requirements.

Program Requirements

Rehabilitative Mental Health Services and Targeted Case Management:

Staff who are employed by a Certified Mental Health Rehabilitation Provider may deliver services inside or outside of the certified site and bill SD/MC. All services provided must comply with all federal, state and local laws and regulations pertaining to rehabilitative services for persons with mental illness.

Physician Availability:

Providers shall have a written procedure for referring Individuals to a psychiatrist when necessary. If a psychiatrist is not available, a physician may be utilized in this capacity. The provider shall maintain a list of psychiatrists and physicians available to provide consultation or direct service.

Staffing:

1. Scope of Practice:

   Services shall be provided within the staff person's scope of practice. The local mental health director shall be responsible for assuring that services provided are commensurate with the professionalism and experience of the staff utilized.

2. Head of Service:

   Each provider shall have a staff person who meets requirements specified in Title 9, Section 622 - 630.

3. Day Treatment:

   Each provider shall maintain a minimum qualifying staff/individuals ratio of 1:8 for Day Treatment Intensive or 1:10 for Day Rehabilitation.

4. Crisis Stabilization/Emergency Room and Crisis Stabilization/Urgent Care:

   Each provider shall maintain a minimum qualifying staff/individuals ratio of 1:4.

Application Information

SD/MC Provider Certification for Residential Treatment Programs Not Currently Certified and Licensed as a Social Rehabilitation Program/Facility:

If your county has providers of adult treatment services or a crisis residential treatment services that are not currently certified as a social rehabilitation programs (Title 9) and licensed as a social rehabilitation facilities or community care facilities or with a permit to operate as a Mental Health Rehabilitation Center from the DMH, you must do the following to apply for SD/MC provider certification:

1. Service provider must contact the local Department of Social Services field office to be licensed as an adult residential or social rehabilitation facility, or contact the DMH, Licensing and Certification Unit to be authorized to operate as a Mental Health Rehabilitation Center (pursuant to Section 5768, Welfare and Institutions Code).

2. For certification as a Social Rehabilitation Program (per Title 9, Sections 531 through 536) the service provider must contact the DMH, Licensing and Certification Unit.

3. Once the service provider has obtained the necessary program certification and licensure or authorization, the local mental health director or designee may apply to the DMH for SD/MC provider certification under the same procedures described under "Request for Participation" (see page 7-8).

SD/MC Provider Certification for Crisis Stabilization-Emergency Room and Crisis Stabilization-Urgent Care:

For counties with providers seeking to deliver Crisis Stabilization Services, the provider must be licensed as a 24 hour health care facility, including a psychiatric health facility, or hospital-based outpatient program (Crisis Stabilization-Emergency Room); or the provider must be certified as a Mental Health Rehabilitation Site (Crisis Stabilization-Urgent Care). Services include an immediate response to an individual exhibiting acute psychiatric symptoms, and shall be provided for less than 24 hours. Please see Chapter 2, Service Definitions for the Rehabilitation Option and Targeted Case Management, for a more detailed description.

Outpatient Hospital Services (OHS):

OHS Operating Under the License of a Hospital:

Outpatient Hospital Services operating under the license of a hospital may provide SD/MC services, in compliance with licensing requirements in the California Code of Regulations, Title 22, Section 51113. Services may be provided either on the premises or offsite. Hospitals will continue to be licensed by the Department of Health Services, Licensing and Certification Division. Certification of these providers will not come under the purview of these standards.

SD/MC Modes of Service:

Applications for Provider Certification or recertification must specify the SD/MC Modes of Service. The provider is limited to providing specified SD/MC modes of service. A recertification application must be submitted to change SD/MC modes of service.

The SD/MC Modes of Service (for non-inpatient hospital services) are as follows:

05 - Residential (including PHF's with a bed capacity of 16 or less)

12 - Outpatient Hospital Service

18 - Non-residential Rehabilitative or Case Management Services

Response by the State Department of Mental Health:

Within 60 days after receipt of a completed application, the DMH will notify the applicant whether the application is approved or denied, or what additional information is needed to approve or deny the application.

The earliest date a new provider can be certified, regardless of the actual on-site review, is the latest date all of the following conditions have been met:

1) Complete application is received in the Medi-Cal Oversight Regional Office;

2) The date the program is operational;

3) The date of the fire clearance.

Recertification:

Confirmation of continued compliance with all SD/MC requirements. Routine SD/MC provider recertification reviews which are done every two years are based on the DMH, Medi-Cal Oversight's Regional recertification review schedule. Additional certification reviews may become necessary if:

A. The provider makes major staffing changes.

B. The provider makes organizational and/or corporate structure changes (example: conversion from nonprofit status).

C. The provider adds day treatment or medication support services when medications will be administered or dispensed from the provider site.

D. There are significant changes in the physical plant of the provider site (some physical plant changes could require a new fire clearance).

E. There is a change of ownership or location.

F. There are complaints regarding the provider.

G. There are unusual events, accidents, or injuries requiring medical treatment for clients, staff or members of the community. (See 7-12)

Reporting Unusual Occurrences:

Continued participation in the SD/MC program requires that providers report unusual occurrences to the DMH Medi-Cal Over sight Regional Office. An unusual occurrence is any event which jeopardizes the health and/or safety of clients, staff and/or members of the community; including but not limited to physical injury and death.

Unusual occurrences are to be reported to DMH within five calendar days of event or as soon as possible after becoming aware of the unusual event.

Reports are to include the following elements:

1. Complete written description of event including outcome.

2. Written report of providers investigation and conclusions.

3. List of persons directly involved and/or direct knowledge of event.

The Department retains the right to independently investigate unusual occurrences with the cooperation of the provider.

Change of Ownership or Location, and Program Changes

The local mental health director or designee shall notify the appropriate DMH, Medi-Cal Oversight Regional Chief (see Page 7-8) 60 days prior to the changes noted below. The notification should include the effective date, and a description of the changes.

1. Change of Ownership Only:

   Sixty days prior to the anticipated change of ownership, the local mental health director or designee must request a new provider number from the DMH Headquarters - Performance Outcome Reporting Section.

   The local mental health director or designee must also submit a Medi-Cal Provider Data Form, available from the Medi-Cal Oversight regional office on request.

2. Change of Ownership or Location (the following applies to both):

   Sixty days prior to the change of ownership or location, the local mental health director or designee must inform the DMH, Medi-Cal Oversight regional office of the following:

   - The current provider name, number and date of termination, if applicable.
   - Name of the new provider, if applicable.
   - New address of provider, if applicable.
   - Date of ownership or location change.
   - Any major staff or program changes.
   - A new fire safety inspection and corrections for the new address.

(Involuntary changes of location due to disasters should be reported as soon as possible and are not subject to the 60 day prior notification requirement.)

3. Planned structural changes requiring a new fire clearance.

4. The provider adds day treatment or medication support services when medications will be administered or dispensed from the provider site.

NEW SHORT-DOYLE/MEDI-CAL PROVIDER CERTIFICATION APPLICATION

Instructions: The Local Mental Health Director or designee must submit a separate application for each provider.

IDENTIFYING INFORMATION	Name of Provider	Provider No. (If one has already been assigned)
	Street Address, City, State and Zip	
	Telephone No.	County
	Contract Agency ☐ or County Operated ☐	
NAME AND ADDRESS OF LEGAL ENTITY		
HEAD OF SERVICE NAME:	Head of Service is: Psychiatrist ☐ Registered Nurse ☐ Psychologist ☐ Psychiatric Tecnician ☐ Licensed Clinical Service Worker ☐ Licensed Vocational Nurse ☐ Marriage , Family and Child Counselor ☐ MH Rehab Specialist ☐	
SHORT-DOYLE/ MEDI-CAL SERVICE MODES TO BE PROVIDED	SD/MC Mode 05 (Crisis Residential or Adult Residential) ☐ SD/MC Mode 18 (Mental Health Services, Medication Support Services, Day Treatment Intensive, Day Rehabilitation, Crisis Intervention, Crisis Stabilization, Crisis Stabilization ER & UC, PHF, and/or Case Management/Brokerage) ☐	
IS THE PROVIDER CURRENTLY LICENSED BY A STATE AGENCY?	Yes ☐ If Yes, which agency? ☐ DMH No ☐ ☐ DHS ☐ DSS ☐ Drug & Alcohol ☐ Other	
FIRE SAFETY	☐ Attached is documentation of the most recent fire safety inspection and correction of deficiencies or a statement from the Local Mental Health Director assuring that all fire safety requirements have been met. ☐ All services are provided at a public school site and meet school fire safety rules and regulations	

I certify that this application is true, correct, and complete. I agree that if approval is granted that all services rendered by the Rehabilitative Mental Health Program shall be in conformity with federal, state and local laws. I further understand that a violation of such laws will constitute grounds for withdrawal of certification. This information may be released to any persons or organizations outside the official administrative channels.

Local Entity Authorized Signature Date:

Local Mental Health Director or Designee Signature Date:

Pharmaceutical Services

1.0 POLICIES AND PROCEDURES:

Each service provider offering medication services shall develop and implement written policies and procedures for the safe and effective distribution, control, storage, use, and disposition of drugs. Policies and procedures shall conform to the requirements of federal and state laws.

2.0 ORDERS FOR DRUGS:

No drugs shall be administered except upon the order of a person lawfully authorized to prescribe for and treat human illness. All drug orders shall be in writing and signed by the person giving the order. The name, quantity or duration of therapy, dosage, and frequency of administration of the drug, the route of administration if other than oral, and the site of injection when indicated shall be specified.

Verbal orders may be received by a licensed pharmacist, licensed registered nurse, licensed vocational nurse, or a licensed psychiatric technician. Verbal orders may be recorded immediately in the client's health record by the person receiving the order and shall include the date and time ordered. Such orders shall be signed by a prescriber within five days.

3.0 LABELING AND STORAGE OF DRUGS:

A. Containers which are cracked, soiled, or without secure closure shall not be used. Drug labels shall be legible.

B. All drugs obtained by prescription shall be labeled in compliance with federal and state laws. No person other than a pharmacist or a physician shall alter any prescription label.

C. Nonlegend drugs shall be labeled in conformance with federal and state laws.

D. Test reagents, germicides, disinfectants, and other non-ingestible substances shall be stored separately from drugs.

E. Drugs intended for external use only shall be stored separately.

F. All drugs shall be stored at appropriate temperatures. Drugs requiring room temperature shall be stored in a place maintained between 15-30 degrees Centigrade (59-86 degrees Fahrenheit). Drugs requiring refrigeration shall be stored in a refrigerator maintained between 2-8 degrees Centigrade (36-46 degrees Fahrenheit). Drugs stored in a refrigerator used also for food storage shall be confined to a closed container clearly labeled "DRUGS."

G. Drugs shall be stored in an orderly manner in cabinets, drawers, or carts of sufficient size to prevent crowding.

H. Drugs shall be stored in a secure area accessible only to personnel designated in writing by the facility.

I. Drugs shall not be retained after the expiration date indicated on the label. No contaminated or deteriorated drugs shall be available for use.

J. Drugs being retained and stored for specific clients shall remain in their original containers.

4.0 DISPOSAL OF DRUGS:

Drugs which are expired or removed from stock due to contamination, deterioration, or which have been abandoned by individuals shall be disposed of in a manner consistent with federal and state law. A log must be kept of all drugs destroyed.

5.0 ADMINISTRATION OF DRUGS:

A. As used in these requirements, administer means the direct application of a substance, whether by injection, inhalation, ingestion, or any other means, to the body of a client for his immediate needs.

B. Drugs shall be administered as prescribed. Each dose administered shall be recorded in the client's record.

C. Drugs shall be administered by persons lawfully authorized to do so.

6.0 DISPENSING OF DRUGS:

A. As used in these requirements, dispense means the furnishing of drugs or devices upon the lawful order of a practitioner, including the furnishing, packaging, labeling, or compounding necessary to prepare the substance for that delivery.

B. Drugs shall be dispensed only by a person lawfully authorized to do so.

DEFINITIONS

(Arranged Alphabetically)

ACADEMIC EDUCATION

Educational activities in which the focus is on learning information for the purpose of furthering one's scholastic ability.

ADOLESCENT

A minor aged 12 through 18, adolescents receiving AB 3632 (Chapter 26.5) services are included through age 22. This Individual may participate in planning activities and sign his/her Coordination Plan and Service Plans, at the discretion of the service provider and family.

ADULT RESIDENTIAL

Rehabilitation services provided in a non-institutional residential setting where Individuals are supported in their efforts to restore, maintain and apply interpersonal and independent living skills, and community support systems. Programs shall provide a therapeutic community including a range of activities and services for Individuals who would be at risk of hospitalization or other institutional placement if they were not in the residential treatment program. This is a structured package program with services available day and night, seven days a week.

ASSESSMENT

Assessment is a clinical analysis of the history and current status of the Individual's mental, emotional, or behavioral disorder. Relevant cultural issues and history may be included where appropriate. Assessment may include diagnosis and use of testing procedures.

BACHELOR'S DEGREE IN MENTAL HEALTH RELATED FIELD

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

COORDINATION PLAN (CP)

The Individual's plan under Coordinated Services which describes certain Short-Doyle/Medi-Cal services provided to an Individual receiving Coordinated Services. Mental Health Services, Day Treatment Intensive, Day Rehabilitation, Adult Residential, and Medication Support when provided in addition to one of these services and providers must be specified on this plan to claim Short-Doyle/Medi-Cal reimbursement following the Intake Period or one month after service contact, whichever is later. The Coordination Plan must be signed by a Licensed Practitioner of Healing Arts, if the Coordinator does not meet those qualifications.

COORDINATOR

This person or team provides the primary point of coordination for each Individual receiving certain services under Coordinated Services. He/she is responsible for developing the Coordination Plan with the Individual and approving Service Plans for Mental Health Services, Day Treatment, Day Rehabilitation, Adult Residential, and Medication Support Services when provided in addition to one of these services.

COUNTY

In the context of Coordinated Services, county means the collective service providers (public and/or private), who seek reimbursement through the Short-Doyle/Medi-Cal program, for the provision of coordinated services under the Rehabilitation Option to eligible Individuals. This applies to city mental health programs that also provide Short-Doyle/Medi-Cal services.

CRISIS INTERVENTION

Crisis Intervention is a quick emergency response service enabling the Individual to cope with a crisis, while maintaining his/her status as a functioning community member to the greatest extent possible. Crisis is an unplanned event that results in the Individual's need for immediate service intervention. Crisis Intervention services are limited to stabilization of the presenting emergency. This service does not include Crisis Stabilization - Emergency Room or Crisis Stabilization - Urgent Care.

CRISIS RESIDENTIAL

Therapeutic and/or rehabilitation services provided in a 24-hour residential treatment program as an alternative to hospitalization for Individuals experiencing an acute psychiatric episode or crisis, and who do not present medical complications requiring nursing care. Individuals are supported in their efforts to restore, maintain and apply interpersonal and independent living skills, and access community support systems. Interventions which focus on symptom reduction shall also be available. This is a structured, packaged program with services available day and night, seven days a week.

CRISIS STABILIZATION - EMERGENCY ROOM

This is an immediate face-to-face response lasting less than 24 hours, to or on behalf of an Individual exhibiting acute psychiatric symptoms, provided at a 24 hour health facility as allowable under the facility licensure. Services must be provided in a distinct and separate part of the facility, and shall be available 24 hours per day. The goal is to avoid the need for Inpatient Services by alleviating problems which, if not treated, present an imminent threat to an Individual's or other's safety or substantially increase the risk of the Individual becoming gravely disabled.

CRISIS STABILIZATION - URGENT CARE

This is an immediate face-to-face response lasting less than 24 hours, to or on behalf of an Individual exhibiting acute psychiatric symptoms, provided in a certified mental health rehabilitation provider site. Services must be provided in a distinct and separate part of the facility, and shall be available 24 hours per day. The goal is to avoid the need for Inpatient Services by alleviating problems which, if not treated, present an imminent threat to the Individual or other's safety or substantially increase the risk of the Individual becoming gravely disabled.

DAY REHABILITATION

Day Rehabilitation provides evaluation, rehabilitation and therapy to maintain or restore personal independence and functioning consistent with requirements for learning and development. This is an organized and structured program which provides services to a distinct group of Individuals. Day Rehabilitation is a packaged program with service available at least 3 hours and less than 24 hours each day the program is open.

DAY TREATMENT INTENSIVE

Day Treatment Intensive service provides an organized and structured multi-disciplinary treatment program and an alternative to hospitalization, to avoid placement in a more restrictive setting, or maintain the Individual in a community setting. These services are provided to a distinct group of Individuals and occur in a therapeutic, organized and structured setting. Day Treatment Intensive is a packaged program with service available at least 3 hours and less than 24 hours each day the program is open.

DESIRED RESULT

Desired results describe what the Individual wants assistance with in specified life areas. The Individual and the Coordinator shall work together to determine how the mental health system, given current resources, can help the Individual achieve their desired result(s). A desired result should be expressed in the Individual's own words.

DURATION

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

Social Worker

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

Marriage, Family, and Child Counselor

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

Registered Nurse

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

Licensed Vocational Nurse

Licensed Vocational Nurse means a person possessing a valid license to practice vocational nursing granted by the California Board of Vocational Nurse and Psychiatric Technician Examiners, and six (6) years post license experience in a mental health setting. Up to four (4) years college or university education may be substituted for the experience on a year-to-year basis.

Psychiatric Technician

Psychiatric Technician means a person possessing a valid license to practice as a psychiatric technician granted by the California Board of Vocational Nurse and Psychiatric Technician Examiners, and six (6) years post license experience in a mental health setting. Up to four (4) years college or university education may be substituted for the experience on a year-to-year basis.

Mental Health Rehabilitation Specialist

Mental Health Rehabilitation Specialist means 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 experience in a mental health setting.

HOSPITAL INPATIENT (See Inpatient Hospital Services)

INDIVIDUAL

A person receiving Short-Doyle/Medi-Cal services under the Rehabilitation Option and/or Targeted Care Management..

INDIVIDUAL RECORD

The documentation of services provided for a specific mode of service at a specified provider.

INDIVIDUAL SERVICE PLAN (See Service Plan)

INPATIENT HOSPITAL SERVICES

Inpatient Hospital Services are ordinarily furnished in a general acute hospital for the care and treatment of an acute episode of illness under the direction of a physician. They are provided in an institution that:

a. Is maintained primarily for the care and treatment of individuals with disorders other than tuberculosis and mental diseases;
b. Is licensed or formally approved as a hospital by an officially designated authority for State standard setting;
c. Meets the requirements for participation in Medicare; and,
d. Has in effect a DMH approved UR plan applicable to all Medi-Cal eligible individuals.

INPATIENT PSYCHIATRIC HOSPITAL SERVICES

Inpatient Psychiatric Hospital Services are furnished under the direction of a physician providing diagnosis, treatment, and/or care to Short-Doyle/Medi-Cal eligible individuals, age 20 or younger, and 65 and older with mental disorders in an acute psychiatric hospital. These services are billed as Inpatient Hospital services.

INTAKE PERIOD

For Coordinated Services, this period begins on the date the Individual first receives any of the following: Mental Health Services: Day Treatment Intensive, Day Rehabilitation, Adult Residential, Medication Support or Targeted Case Management. This period ends at the end of two months.

LEGAL ENTITY

A county or city mental health department or agency, or a corporation, partnership, or agency or individual practitioner providing public mental health services under contract with the county or city mental health department or agency.

MEDICATION SUPPORT SERVICES

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

MENTAL HEALTH REHABILITATION SPECIALIST

A mental health rehabilitation specialist is an individual who has a baccalaureate degree and four years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment. Up to two years of graduate professional education may be substituted for the experience requirement on a year-for-year basis. Up to two years of post associate arts clinical experience may be substituted for the required educational experience (as defined in Title 9) in addition to the requirement of four years of experience in a mental health setting.

MENTAL HEALTH SERVICES

Mental Health Services are interventions designed to provide the maximum reduction of mental disability and restoration or maintenance of functioning consistent with the requirements for learning, development, independent living and enhanced self-sufficiency. Services shall be directed toward achieving the Individual's goals/desired results/personal milestones.

MILESTONES (See Personal Milestones)

MONTH OF INTAKE SCHEDULE - COORDINATED SERVICES

The Month of Intake Schedule refers to specific time frames for the completion of the Coordination Plan for each Individual receiving Mental Health Services, Day Treatment Intensive, Day Rehabilitation, Adult Residential Services, or Medication Support Services when provided in addition to one or more of these services. The Month of Intake Schedule also refers to specific time frames for the completion of Service Plans for Mental Health Services, Day Treatment Intensive, Day Rehabilitation or Adult Residential Services. The due date for an Individual's Service Plans and Coordination Plan are based on the month of his/her intake. The Month of Intake Schedule revolves on the first day of the month of intake. The Month of Intake is the month the Individual first receives any of the following services: Medication Support, Case Management/Brokerage, Mental Health, Day Treatment Intensive, Day Rehabilitation, or Adult Residential Services.

OCCUPATIONAL THERAPIST

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

REGISTERED NURSE

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

REHABILITATION

This service activity may include any or all of the following: assistance in restoring or maintaining an Individual's or group of Individual's a) functional skills, b) daily living skills, c) social skills, d) grooming and personal hygiene skills, e) meal preparation skills, f) medication compliance, and g) support resources; Individual and family counseling; training in leisure activities integral to achieving the Individual's goals/desired results/personal milestones.

REHABILITATIVE MENTAL HEALTH SERVICES

Rehabilitative Mental Health Services are medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his/her practice under state law, for the maximum reduction of mental disability and restoration of a recipient to his best possible functional level, when provided by local public community mental health agencies and other mental health service providers licensed or certified by the State of California. Services are provided based on medical necessity and in accordance with a coordination plan, treatment plan, or service plan approved by a licensed physician or other licensed practitioner of the healing arts, excluding crisis services for which a service plan is not required. Rehabilitative mental health services are provided in the least restrictive setting appropriate for reduction psychiatric impairment, restoration of functioning consistent with the requirements for learning and development, and/or independent living and enhanced self-sufficiency. (California State Plan Amendment 82-10)

SERVICE CONTACT

Face -to-face or phone contact with the Individual or significant other.

SERVICE DELIVERY STAFF

Service delivery staff means provider staff directly involved in the provision of Short-Doyle/Medi-Cal service under the Rehabilitation and Targeted Case Management Options to Individuals.

SERVICE NECESSITY

A level of functional impairment demonstrating need for Case Management/Brokerage.

SERVICE PLAN

A written document which identifies the specific plan of care by a provider for Mental Health, Day Treatment Intensive, Day Rehabilitation, or Adult Residential Services in Coordinated Services. In Traditional Quality Assurance, a comprehensive Plan of Care for Mental Health Services.

UNIT OF SERVICE

Units are a means of measuring the volume of service provided. See Comparison of Services Functions, Chapter 2, for unit of service definition for each service function.

UNPLANNED SERVICES

Unplanned services include Crisis Intervention, Crisis Stabilization - Emergency Room, Crisis Stabilization - Urgent Care, Crisis Residential Treatment, Psychiatric Health Services, and Inpatient Hospitalization.

UTILIZATION CONTROL (UC) (Coordinated Services)

Utilization Control is the prior approval of services.

UTILIZATION REVIEW (UR)

Utilization Review is the system designed to determine the medical/service necessity for services under the Rehabilitation Option, Targeted Case Management and compliance with minimum standards.

WAIVER

A waiver of licensure granted by the State Department of Mental Health to any Licensed Clinical Social Worker (LCSW), Psychologist (Ph.D.), and Marriage, Family and Child Counselor (MFCC) candidate that is accruing clinical hours in accordance with the requirements of the appropriate licensing agency. Persons with these waivers will be considered as licensed.

WINDOW PERIOD

The Window Period refers to specific timelines for the review and revision of the Individual's Service Plan, Treatment Plan, Coordination Plan and Community Functioning Evaluation. A Plan/Evaluation signed any time during the Window Period shall be effective for the subsequent period. The specific timeline for the Window Period (Traditional Quality Assurance) is 15 days prior to the expiration of the current Treatment Plan, Service Plan and Utilization Review for the next authorized six month period for Mental Health Services or Adult Residential and the next three month period for Day Rehabilitative Services.