

DHCS



Department of
HealthCareServices

**MEDI-CAL
DOCUMENTATION AND CLAIMING MANUAL**

**Intensive Care Coordination (ICC)
And
Intensive Home-Based Mental Health Services (IHBS)**

Mental Health Services Division
California Department of Health Care Services

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CHAPTER 1

HISTORY AND INTENT OF THE DOCUMENTATION MANUAL

On July 18, 2002, a lawsuit entitled *Katie A. et al. v. Diana Bonta et al.* was filed seeking declaratory and injunctive relief on behalf of a class of children in California who (1) are in foster care or are at imminent risk of foster care placement, (2) have a mental illness or condition that has been documented or—if an assessment had been conducted—would have been documented, and (3) need individualized mental health services, including, but not limited to, professionally acceptable assessments, behavioral support and case management services, family support, crisis support, therapeutic foster care, and other medically necessary services in the home or in a home-like setting, to treat or ameliorate their illness or condition.

In December, 2011, a settlement agreement was reached in the case. As part of this agreement, the California Department of Health Care Services (DHCS) and the California Department of Social Services (CDSS) agreed to perform a number of actions, including the development and distribution of this Documentation Manual, with the following objectives:

- To facilitate the provision of an array of services delivered in a coordinated, comprehensive, community-based fashion that combines service access, planning, delivery and transition into a coherent and all-inclusive approach, hereinafter referred to as the Core Practice Model or CPM, as defined in Chapter 2.
- To address the need for subclass members with more intensive needs to receive medically necessary mental health services that include Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS) and Therapeutic Foster Care (TFC). (The descriptions for IHBS and ICC are described fully in Chapter 3, *supra*)¹.
- To clarify and provide guidance on the coverage and documentation requirements under Medi-Cal of IHBS and ICC so that counties and providers can understand these requirements and consistently apply them.

The intent of this Documentation Manual is to:

- Inform and instruct Mental Health Plans and providers on the provision, documentation and claiming of two Medi-Cal covered services, Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS). These services are to be provided to the “sub-class” of children covered by the Katie A. settlement, as defined in Chapter 2 of this Manual, and in accordance with the principles and components of the Core Practice Model, as defined in Chapter 2.

¹ This manual only includes guidance for ICC and IHBS. A supplement or addendum to the Documentation Manual will be published at a later date to provide guidance on TFC.

- Provide information on the following topics and issues:
 - Guidance on which other Medi-Cal covered Specialty Mental Health Services can or cannot be provided with ICC and IHBS
 - Coding requirements for claims submission through the Short-Doyle/Medi-Cal Claiming System
 - General description of non-reimbursable Medi-Cal service activities which can be part of the ICC/IHBS unified arrays of services
 - Documentation requirements and guidelines for ICC and IHBS
 - Where to find additional information on the Core Practice Model

This Documentation Manual has been developed by the Department of Health Care Services (DHCS) in collaboration with the Katie A Negotiation Workgroup and other stakeholders. This Documentation Manual is consistent with, ***but does not replace***, the state and federal Medicaid statutes and regulations, the California Medicaid State Plan and any approved amendments, and the contract between DHCS and the Mental Health Plans (MHPs). This manual is intended to supplement other general state guidance on Specialty Mental Health Services that has been issued by the Department; this manual is the only official guidance on ICC and IHBS documentation and billing and shall be followed by the MHPs and providers.

This manual is also intended to be read in conjunction with the Core Practice Model (CPM) that will be published by the California Department of Social Services (CDSS). The CPM is a model of care and service delivery which adheres to a prescribed set of family centered values and principles that are driven by a defined child and family team process, and would be utilized by all agencies or individuals who serve class members and their families. The *CPM Guide* was also specifically developed pursuant to the Katie A. settlement agreement. To view or obtain a copy of the CPM Guide, please go to [www.dhcs.xxx]].

SERVICE DELIVERY CONCEPTS

A. Katie A. Subclass

Subclass Members are children and youth who are full-scope Medi-Cal eligible, meet medical necessity, have an open child welfare services case, and meet either of the following criteria:

1. Child is currently in or being considered for: Wraparound, therapeutic foster care or other intensive services, therapeutic behavioral services (TBS), specialized care rate due to behavioral health needs or crisis stabilization/intervention; or
2. Child is currently in or being considered for a group home (RCL 10 or above), a psychiatric hospital or 24 hour mental health treatment facility, or has experienced his/her 3rd or more placements within 24 months due to behavioral health needs.

Note: It is the responsibility of the Mental Health Plans (MHPs) to establish policies and procedures for determining and documenting Katie A subclass membership for Medi-Cal beneficiaries. A copy of the

documentation used by the MHP to establish subclass membership must be placed in the beneficiary's medical record when these covered services are authorized and provided to the certified subclass member. Please see Addendum X for the subclass membership form.

B. Core Practice Model

The Core Practice Model, which would be utilized by all agencies, or individuals who serve class members and their families, adheres to a prescribed set of family centered values and principles that are driven by a definable process. The Core Practice Model values and principles are summarized as follows:

- Services are needs-driven, strengths-based, and family-focused from the first conversation with or about the family.
- Services are individualized and tailored to the strengths and needs of each child and family.
- Services are delivered through a multi-agency collaborative approach that is grounded in a strong community base.
- Family voice, choice, and preference are assured throughout the process.
- Services incorporate a blend of formal and informal resources designed to assist families with successful transitions that ensure long-term success.
- Services are culturally competent and respectful of the culture of the children and their families.
- Services and supports are provided in the child and family's community.
- Children are first and foremost protected from abuse and neglect and maintained safely in their own homes.
- Children have permanency and stability in their living situations.

In order to benefit from the full array of services they need, at whatever level appropriate and necessary to meet their needs, class members will be best served through five key practice components that are organized and delivered in the context of an overall child and family plan. These five components include the following:

- 1) *Engagement*: Engaging families is the foundation to building trusting and mutually beneficial relationships between family members, team members, and service providers. Agencies involved with the child and family work to reach agreement about services, safety, well-being (meeting attachment and other developmental needs, health, education, and mental health), and permanency.
- 2) *Assessing*: Information gathering and assessing needs is the practice of gathering and evaluating information about the child and family, which includes gathering and assessing strengths as well as assessing the underlying needs. Assessing also includes determining the capability, willingness, and availability of resources for achieving safety, permanence, and well-being of children.
- 3) *Service Planning and Implementation*: Service planning is the practice of tailoring supports and services unique to each child and family to address unmet needs. The

plan specifies the goals, roles, strategies, resources, and timeframes for coordinated implementation of supports and services for the child, family, and caregivers.

- 4) *Monitoring and Adapting*: Monitoring and adapting is the practice of evaluating the effectiveness of the plan, assessing circumstances and resources, and reworking the plan as needed. The team is responsible for reassessing the needs, applying knowledge gained through ongoing assessments, and adapting the plan in a timely manner.
- 5) *Transition*: The successful transition away from formal supports can occur when informal supports are in place and providing the support and activities needed to ensure long-term stability.

C. Child and Family Team

A subset of Katie A. class members need a more intensive approach and service delivery to address their array of needs and strengths, and it has been determined that this subset would best be served through a formally organized *Child and Family Team*.

In those instances where intensive or complex needs are identified, a formal Child and Family Team would be created to serve as the primary vehicle delivering services in accord with the Core Practice Model in order to bring significant individual team members together to help the family develop a plan of care that addresses their needs and strengths. The principle role of the Child and Family team would be as follows:

- The Child and Family Team (CFT) assembles as a group of caring individuals to work with and support the child and family and, in addition to the various agency and provider staff involved in service delivery to the family, includes at a minimum a facilitator and a family support partner or family specialist for youth.
- Team facilitation can be done by a mental health provider, social worker, or probation officer. The facilitator maintains a committed team and is qualified with the necessary skills to bring resources to the table in support of the child and family.
- An effective CFT continues the process of engagement with the family and or caregivers about their strengths and needs, ensures services are well coordinated, and provides a process for transparent communication.

CHAPTER 2

OVERVIEW OF ICC AND IHBS

ICC and IHBS should be provided in accordance with the requirements and guidelines for SMHS which are established in the Medi-Cal State Plan and its amendments, the MHP Contract and at Title 9, Division 1, and Chapter 11 of the California Code of Regulations.

The Katie A. Settlement Agreement specifies that all children who meet the subclass criteria shall receive ICC and IHBS when it is determined by the MHP or contracted provider to be medically necessary in accordance with federal and state law, the State Medicaid Plan and state policies and procedures governing SMHS.

Individual Care Plan

The Individual Care Plan (ICP) is the document which facilitates implementation of the values, principles and practice components of the CPM. The ICP is the cross-system/multi-public service agency plan developed by the Child and Family Team (CFT) which specifies the:

- i) multi-agency services to be delivered through a collaborative approach;
- ii) the blend of formal and informal resources designed to assist families with successful transitions that ensure long-term success;
- iii) interventions to be provided in the most home-like/natural setting possible in the child/family's community; and
- iv) determines the capability, willingness and availability of all community resources available to the child and family.

The ICP is created under the guidance of the care coordinator through the CFT process. The care coordinator can be any public agency staff person assigned to work with the child and family (or an informal significant support person) including a mental health provider, social worker, teacher or school staff person, probation or court official or other individual. The ICP may directly include, but at a minimum, must incorporate by reference, the child/youth's Medi-Cal SMHS assessment and client plan which specify the goals and objectives for the ICC and IHBS which have been authorized by the MHP.

1. Intensive Care Coordination (ICC)

Intensive Care Coordination (ICC) is a covered Medi-Cal SMHS Targeted Case Management (TCM) service for children whom the MHP certifies as being Katie A. "subclass" members. ICC as a case management service facilitates implementation of the cross-system/multi-agency collaborative services approach described in the CPM. This includes the ICC provider (e.g. the Medi-Cal SMHS case manager) helping to establish and working with the CFT in developing the ICP. ICC activities that are Medi-Cal covered for subclass members include the following: facilitating care planning and coordination of services, including assessing the need for urgent mental health services for children and youth who meet the *Katie A.* subclass criteria defined in Chapter 1. To the extent that it is within their scope of practice, the ICC/case manager may participate in and provide information to SMHS providers completing the child's mental health assessment and SMHS client plan.

For Katie A. “sub-class” children, the ICC/case manager provides:

- A single point of accountability for ensuring that medically necessary mental health services included in the child’s SMHS client plan are accessed, coordinated, and delivered in a strength-based, individualized, family/youth-driven, and culturally, and linguistically relevant manner;
- Mental health services and supports that are guided by the needs of the youth;
- Facilitation of and participation in a collaborative relationship among a youth, his/her family, other Medi-Cal SMHS providers, and other involved child-serving systems concerning the child’s diagnosed mental health condition contained in the child’s SMHS client plan;
- Support for the parent/caregiver in meeting the youth’s mental health treatment and care coordination needs as described in the child’s SMHS client plan;
- Participation in and facilitation of a care planning process which ensures that the ICC case manager organizes and matches mental health care across providers and child serving systems to allow the youth to be served in his/her community;
- Facilitated development of the Child and Family Planning Team (CFT) in collaboration with other service agencies and staff serving the child.²

ICC specialty mental health service components to be provided to subclass members are as follows:

Initial ICC Case Management Assessment: The ICC case manager participates with the CFT to assess initial information about the child’s mental health condition to incorporate in the strength-based, needs driven, comprehensive cross-system/multi-agency assessment to create the Individual Care Plan (ICP) and a risk management/safety plan. The initial ICC and overall ICP assessment process determines the needs of the youth for any medical, educational, social, mental health, or other services. ICC may also include the planning and coordination of medically necessary urgent mental health treatment based on the child’s diagnosed mental health condition.

The ICC case management plan that is completed based on the initial ICC assessment should be reviewed and updated as necessary, but at least every 90 days.

The ICC provider also works with other Medi-Cal SMHS providers to facilitate completion of the Mental Health Assessment and SMHS client plan. The ICC case manager takes information from the child’s SMHS assessment and client plan to discuss with the CFT and incorporate in the ICP.

Planning: Development of an Individual Care Plan (ICP): Using the information which the MHP has collected through the child’s initial ICC case management assessment and client plan (if this has already been completed), the ICC provider convenes and facilitates the CFT meetings and the CFT develops the child and family centered ICP which specifies the goals and actions needed to address the child’s overall cross-system/multi-agency medical, educational, social, mental health, or other services needed by the youth and family. The ICC case manager works directly with the youth, the family, other Medi-Cal SMHS providers, and others significant to the child to identify strengths and needs of the child and family related to the child’s diagnosed mental health condition contained in the child’s SMHS client plan and the ICP, as well as to develop a plan for meeting those needs and goals.

² The CFT includes, as appropriate, both formal supports, such as the care coordinator, providers, case managers from child-serving agencies, and natural supports, such as family members, neighbors, friends, and clergy.

Referral, Monitoring and Related Activities: ICC also includes the following service activities:

- Working directly with the youth and family to implement the mental health elements of the SMHS client plan and ICP;
- Preparing, monitoring, and modifying the mental health treatment components of the SMHS client plan and the ICP in concert with the CFT;
- Determining whether the mental health services in the SMHS client plan and ICP are adequate to meet the mental health needs in the child's current child and family environment;
- Determining whether there have been changes in the mental health needs or status of the youth identified in the SMHS client plan and ICP, and, if so, adjusting the mental health plan and ICP as necessary, in concert with the CFT;
- Will actively assist the youth and family in obtaining and monitoring the delivery of available services necessary to address the child's diagnosed mental health condition contained in the SMHS client plan and ICP including medical, educational, mental health, social, therapeutic, or other services.

Transition: ICC also includes:

- Developing with the CFT a transition plan necessary to continue to treat the child's diagnosed mental health condition contained in the child's SMHS client plan when the youth has achieved goals outlined in the ICP;
- Collaborating with the other SMHS service providers and other child-serving agencies concerning the child's diagnosed mental health condition on behalf of the youth and family.

Settings: ICC may be provided to children living and receiving services in the community as well as to children who are currently in a hospital, group home, foster care, relative placement, adoption, or other congregate or institutional placement as part of discharge planning³.

The ICC provider should conduct an initial case management assessment of a child who is referred or being considered for Katie A. services (e.g. determine that the child is eligible as a Katie A. "sub-class" member and assess the need for ICC, IHBS and/or other Medi-Cal SMHS services).

The ICC case managers initial assessment (or the completed case management plan if the child is determined to meet the "sub-class" criteria) forms the basis for the development of ICP, the risk management/safety plan and ultimately the coordination of public social services provided including transition of services, as needed, throughout the episode in which the child needs intensive SMHS services.

Initial ICC Assessment: The initial ICC Assessment is completed in the context of the Child and Family Team (CFT). As discussed above, if the child is determined to need ICC/IHBS, the ICC provider coordinates completion of the ICC Case Management Plan and inclusion of SMHS information into the ICP based on the Comprehensive Mental Health Assessment and SMHS client plan.

³ Information regarding settings was extracted from the Katie A. Settlement Agreement and does not replace state and federal Medicaid statutes and regulations, the California Medicaid State Plan and any approved amendments, and the contract between DHCS and the Mental Health Plans (MHPs).

ICC reflects only case management activities. The SMHS mental health assessment and client plan must be completed by MHP staff whose scope of practice allows for completion of the assessment and client plan. Mental health assessment, collateral, therapy as well as all other Medi-Cal SMHS must be claimed separate from ICC.

The Initial Supplemental ICC Assessment will be used by the provider to determine whether the client is a member of the Katie A. subclass and whether ICC and IHBS are medically necessary.

If the initial ICC Assessment results in a subsequent ICC case management plan, that plan will be reviewed as necessary, but ***at least every 90 days***. This review should be documented in the child's Medi-Cal SMHS medical record consistent with Medi-Cal requirements.

The initial ICC Assessment:

- Will evaluate whether or not the client is a member of the Katie A. subclass.
- For children who meet this threshold, include an initial determination of the child and family's needs and strengths
- Include a comprehensive list of known family including extended family, friends, educational personnel, other professionals, and relevant community based organizations involved in the child's life to inform and support the establishment of the Child and Family Team
- Include a review of current and historical mental health information including services and supports provided and the associated results, as well as other concurrent service information provided during reviews
- Prioritize needs so that urgent issues (those that threaten health, safety, and/or placement stability) are addressed first
- Be used to inform and justify the ICP

Planning (development of the ICP)

If multiple members of the CFT claim for participating in ICC case management activities in development of the ICP, each role and function in treating the child's diagnosed specialty mental health condition must be clearly identified and their contribution must be justified to support the claims.

- Activities and services that are directly related to the identified child needs that can be addressed via mental health services and supports contained in the SMHS client plan of the child are claimable
- Activities and services that are not related to needs associated with mental health services and supports that are addressed in the SMHS client plan of the child and are solely related to other treatments/services (e.g. medical treatment, educational services, probation, housing, vocational) are not claimable
- By their nature, CFT meetings involve multiple parties, each who is contributing to a complex discussion of various needs and strengths of the child and family. This discussion is dynamic and moves from subject to subject according to the process directed by the facilitator and the knowledge, skills, and interests of the various CFT members. There may be several mental health professionals in attendance at the CFT meeting, such as the facilitator, the child and family specialist, the therapist, and others.

These members of the team may claim for time in which they are actively participating in the discussion as it pertains to the mental health needs of the subject child. It should be understood that “active participation” in the context of a CFT meeting can include time spent actively listening, internal dialogue related to formulation of treatment planning, adjusting, and service provision, and mental notes regarding needed follow up activities. It is expected that skilled mental health personnel who participate meaningfully in the CFT process will be able to claim for a substantial portion of their time in the CFT meeting. Chapter 4 provides specific documentation claiming requirements and examples of this.

In addition, in order for their services to be Medi-Cal reimbursable, members of the CFT must:

- (1) Meet one or more of the provider qualification requirements described in Chapter 5 and Appendix III of this Manual;
- (2) Be employed by or under contract to the MHP or employed by one of the MHP’s contracted organizational providers; and
- (3) Shall not be employees of other public service agencies, such as child welfare, education, probation, or public health, etc. who are simultaneously serving the child

Case Conferences and meetings between CFT members, other professionals and/or the family and child are essential services for the monitoring of the ICP. The focus of the conference or meeting must be specific regarding the progress/regression towards improving child’s mental health condition identified in the SMHS client plan and ICP **and** identify a clear plan for follow up by the CFT members.

The ICC Case Management Plan and the overall ICP should reflect the preferences and choices of the child and family in terms of goals and intervention strategies, consistent with the values, culture and/or other factors unique to the child and family. This statement is not intended to be in conflict with legal or other non-negotiable requirements.

Referral, Monitoring and Related Activities

- Referral, monitoring and related activities are services to access, maintain access, and ensure continuity of care to medical, educational, social, prevocational, vocational, adjunctive mental health services or other community based services that are needed to address impairments resulting from the child’s diagnosed specialty mental health condition contained in the child’s SMHS client plan and ICP. Linkage, consultation, placement and plan development in the context of ICC services are some examples of services included.
- ICC facilitates routine CFT meeting intervals appropriate to the level of intensity of the child’s mental health needs identified in the SMHS client plan and ICP to evaluate the effectiveness of the planned specialty mental health interventions, to ensure the plan is being implemented consistent with the ICP document, and to refine the ICP based on results or new information.

- ICC works directly with the youth and family, other members of the CFT, other SMHS providers, and other support persons to implement the goals and interventions of the SMHS client plan that are included in the ICP.
- ICC identifies and develops linkage to additional resources to treat the child's diagnosed mental health condition needed to support the implementation of the ICP and the efforts of the CFT.
 - When a CFT mental health provider is assisting the caregiver in obtaining and securing housing, this activity may be claimable if by obtaining and securing the housing the child's mental health will be directly impacted. For instance, if a child has an anxiety disorder, and is perseverating on not having a home or being safe living in a shelter, obtaining and securing housing may be claimable due to reducing the child's symptoms of anxiety.
 - If the CFT member is assisting the child with linkage to an educational tutor for the sole purpose of academic improvement, and there is no impact on the child's mental health status as a result of academic improvement, this activity is not claimable.

Transition Planning

Transition is planning for life changes in which there is a reasonable expectation of an impact to the child's current diagnosed specialty mental health condition. Transition planning includes many different types of changes that can impact the child's mental health impairments identified in the child's client plan: placement change, level of care change, ending services and beginning new services. As a child makes progress in achieving prioritized goals, the CFT planning, SMHS client plan, and resulting ICP should reflect how that progress will be maintained after ICC services are completed.

- When a child is transitioning from one provider to another, or to a higher or lower level of care, the information sharing and meetings to plan for the impact on the child's diagnosed specialty mental health condition transition must be documented.
- The Assessment and ICP should be updated at the time of transitions. Service documentation must clearly reflect how the transition supports the progress and maintains gains made in the level of functioning and in the child's mental health.

2. Intensive Home-Based Services (IHBS)

In addition to recognizing that children/youth in the Katie A. subclass often need a more complex and interactive service planning process, the Katie A. settlement agreement also provides for a powerful, home-based service approach, known as Intensive Home Based Services (IHBS). This service approach is intended to address the needs of the child/youth that will provide for improved functioning in the home and community and promote maintaining children with their families, whenever possible, and afford placement stability in community settings and long-term permanency where that is not possible.

IHBS are individualized, strength-based rehabilitative specialty mental health services designed to ameliorate mental health conditions identified in the child's specialty mental health client plan that interfere with a child's functioning. Interventions are aimed at helping the subclass member eligible child and their identified support network build and support the skills necessary for successful functioning in the home and community and improving the child's family's ability to help him/her

function successfully. As the name implies, IHBS are expected to be more intensive on domains such as service frequency, service variety, etc. than the standard rehabilitative specialty mental health service provided to children/youth with less intensive needs. IHBS may be delivered on evening, weekends, and holidays consistent with the identified needs of the child/youth and is consistent with a “whatever it takes” approach to service delivery.

IHBS are delivered according to the child/youth’s individualized Medi-Cal SMHS mental health assessment and client treatment plan included or referenced in the ICP. IHBS must be specifically included/authorized in the child’s SMHS client plan and acceptable progress notes for all Medi-Cal claimed services must be maintained in the specialty mental health client plan. The identified medically necessary mental health services may be delivered by phone, in the field or in the office. In order to be covered by the Medi-Cal Specialty Mental Health Services Program, phone contact and consultation (as well as all other services) must meet the medical necessity requirements outlined in *California Code of Regulations (CCR)* Title 9 Section 1830.205 or 1830.210, see Addendum II.

IHBS is to be provided and claimed as a “rehabilitative” mental health service (MHS) under the Short-Doyle Medi-Cal Phase II (SD2) electronic claims processing system procedure code H2015. (See Chapter 6 for a detailed explanation of Administrative and claiming requirements)

In some instances IHBS may appear similar to Therapeutic Behavioral Services (TBS) both in service type and intensity. When this service array is being provided to members of the Katie A. subclass, it should be claimed to IHBS rather than TBS.

IHBS only reflects “rehabilitation” MHS provided to children certified as Katie A. “sub-class” members who typically should receive ICC. The SMHS mental health assessment and client plan development must be completed by MHP staff whose scope of practice allows for completion of the assessment and client plan. Mental health assessment, client plan development, therapy, collateral, medication support as well as any other Medi-Cal SMHS which are medically necessary and appropriately documented in the client plan, may be reimbursed and must be claimed separate from IHBS.

The purpose of IHBS as a “rehabilitation” service is to promote and support the engagement of the child in community activities in accordance with the ICP where the child has an opportunity to work towards identified goals and objectives in a natural setting. The CFT develops goals and objectives for all life domains in the ICP, including those in which the child's mental health condition produces impaired functioning, including family life, community life, education, vocation, and independent living. IHBS providers should attempt to link the specific mental health interventions described in the SMHS client plan to the goals and objectives of the ICP as identified by the CFT. The goals and objectives of IHBS should thus be to treat the child’s diagnosed mental health conditions in order to seek to maximize the child's ability to live and participate in the community and to function independently as described in the ICP, including through building social, communication, behavioral, and basic living skills.

IHBS includes, but is not limited to:

- Educating the child's family about, and training the family in managing, the child's identified mental health disorder;
- Medically necessary skill-based remediation of behaviors, including developing and implementing a behavioral plan with positive behavioral supports directed towards the child’s

diagnosed mental health condition included in the child's SMHS client plan and modeling for the child's family and others how to assist them in implementing behavior strategies;

- Improving self-care and self-regulation, by addressing behaviors and social skills deficits resulting from the child's diagnosed mental health condition (included in the child's SMHS client plan) that interfere with daily living tasks and avoidance of exploitation by others;
- Improving self-management of symptoms resulting from the child's diagnosed mental health condition (included in the child's SMHS client plan), including assisting with self-administration of medications;
- Improving social decorum (e.g. by addressing social skills deficits resulting from and anger management needed due to the child's diagnosed mental health condition included in the child's SMHS client plan);
- Supporting the development and maintenance of social support networks and the use of community resources needed to address the child's diagnosed mental health condition included in the child's SMHS client plan;
- Supporting employment objectives, by identifying and addressing behaviors resulting from the child's diagnosed mental health condition included in the child's SMHS client plan that interfere with seeking and maintaining a job;
- Supporting educational objectives, through identifying and addressing behaviors resulting from the child's diagnosed mental health condition included in the child's SMHS client plan that interfere with succeeding in an academic program in the community;
- Supporting transitional independent living objectives, by identifying and addressing behaviors resulting from the child's diagnosed mental health condition (as included in the child's SMHS client plan) that interfere with seeking and maintaining housing and living independently.

Any of the above interventions must be documented/included in the child's specialty mental health client plan, and linked to the child's functional impairments and mental health diagnosis(es) included in the client plan, in order for the above interventions to be Medi-Cal reimbursable.

Settings: IHBS may be provided in any setting where the child is naturally located, including the home (biological, foster or adoptive), schools, recreational settings, child care centers, and other community settings.

IHBS are individualized, strength-based "rehabilitation" specialty mental health services designed to ameliorate mental health conditions that interfere with a child's successful functioning in home, school and the community. These services are conducted using the CPM and in conjunction with ICC.

Prior to the provision of IHBS the following requirements must be met:

Completion of a Comprehensive Clinical Assessment

- The establishment of a qualifying diagnosis
- Client is identified as member of the qualifying Katie A. "sub-class" (See Assessment Section of manual)
- A medical necessity determination by an LPHA (Licensed Practitioner of the Healing Arts) based on the recommendations of the Child and Family Team.
- Inclusion of IHBS (and ICC) in the child's SMHS client plan or creation of a client plan for a "new" Medi-Cal SMHS client.

IHBS are services that meet the Medi-Cal Specialty Mental Health definition of Rehabilitation Services. Rehabilitation Services address deficits in client's skills by teaching and supporting the development of effective behaviors, alternative means of problem solving, improved self-management of symptoms, stronger social supports, reduced conflict and/or other dynamic means of improved functioning resulting from the child's diagnosed mental health condition.

In order to receive Medi-Cal reimbursement for IHBS services, they must meet Medi-Cal requirements, including the following:

- Medi-Cal specialty mental health medical necessity criteria are met.
- Service is delivered in accordance with the client's Specialty Mental Health Service Plan. Behaviors targeted in the client/service plan are the direct result of a qualifying mental health disorder.
- CFT and other service coordination meetings must specifically discuss the effectiveness of service toward improvement of the child's mental health and functioning **and** establish a clear plan for follow-up. The results of this discussion and plan must be clearly documented in the progress notes supporting all Medi-Cal SMHS claiming.
- A CFT member must be role specific in their documentation of participation in CFT and other service coordination meetings and their contribution to treating the child's diagnosed specialty mental health condition must be justified in the documentation.
- Problems related to alcohol and drug use are clearly related to the qualifying mental health diagnosis included in the child's client service plan and documented as such (e.g., Adolescent client smokes marijuana to mitigate their intense social phobia, which prevents them from developing successful relationships. Youth has a diagnosis of Anxiety Disorder and staff is training alternative or replacement behaviors that are effective to reduce anxiety as a substitute for smoking. Family receives education and support to understand the impact of substances on mental health conditions and approaches to manage a dual diagnosis).
- Services are aimed directly at those conditions and goals identified in the individual's client plans.
- IHBS are services provided for the benefit of the child to improve the child's diagnosed mental health condition and not solely those of the family. Service documentation must clearly identify how the services provided accomplish the stated goals of ameliorating the client's mental health concerns as described in the child's SMHS client plan.

IHBS services are provided directly to the client. Examples of services include, but are not limited to:

- Educating and training the child's family members in managing the child's diagnosed mental health disorder. Client must be present and participate.
- Modeling behavioral change strategies necessary to treat the child's diagnosed mental health condition with the family or support person. Client must be present and participate.
- Providing social skills, self-care or self-regulation training related to treating the child's diagnosed mental health condition to the client.

- Providing specific targeted interventions to treat the child's diagnosed mental health condition such as anger management and other behavioral modification approaches.
- Supporting the development and maintenance of social support networks and use of community resources needed to treat the child's diagnosed mental health condition.
- Supporting educational objectives by addressing behaviors resulting from the child's diagnosed mental health condition that interfere with school success.
- Working with client and family members to identify environmental changes that reduce problem behavior triggers resulting from the child's diagnosed mental health condition, e.g., to reduce stimulation or create greater predictability.
- Supporting development of skills that address the child's diagnosed mental health condition that enable successful transition to independent living or permanency.

All IHBS and SMHS provided, as described above, must be documented appropriately in the child's SMHS client plan. Documentation summarizes the service provided and the result, should adequately inform other care providers of important information, including highly significant events or interactions, and justify the billing for services to Medi-Cal. All notes must fully meet Medi-Cal requirements as indicated in a current Department of Health Care Services annual protocol to avoid the risk of recoupment.

As of the printing of this manual the recoupment manual indicates that the Interdisciplinary Note shall:

- Identify the type of service provided
 - IHBS-Rehabilitation
- Identify to whom service was provided.
- Identify date service was provided.
- Identify location where service was provided.
- Identify precise amount of time services were provided, in minutes (minutes will be converted by the MHP for reimbursement purposes to 15-minute increments equaling one unit of service). Minutes of travel and documentation time can be included in the calculation of the 15-minute increments that equal one unit of service.
- Include the following client identification information in the SMHS client plan: Name, date of birth, chart number, and name of provider organization.
- Indicate the language used during service provision.
- Identify, in detail, in the client plan all specific interventions involved in assisting the client.
- References to assisting client or client's family in the client plan must include specific means of assisting (i.e., modeling, teaching, instructing, role playing, feedback, directing).
- Provide convincing evidence in the client plan that the intervention provided can be reasonably expected to successfully improve client's condition.

- All services identified in the client service plan must address goals and problems identified in service plan.
- All interdisciplinary notes in the client/service plan should reflect medical necessity issues of client.
- Include authorized signature and discipline or job category of provider in the client/service plan, print name clearly.
- Continuation pages should also include signature and name.

DRAFT

CHAPTER 3

MEDICAL NECESSITY CRITERIA, CONCEPTUALIZATION OF MEDI-CAL SMHS (ICC AND IHBS) TREATMENT AND DOCUMENTATION STANDARDS AND GUIDELINES

Medical Necessity Criteria

Medical necessity criteria must be met by all Medi-Cal beneficiaries, including subclass members, in order for a SMHS (including ICC and IHBS) to be reimbursed through the Medi-Cal program. Please see Addendum II for a comprehensive list of all medical necessity criteria components. Listed below are the critical components of the SMHS medical necessity criteria.

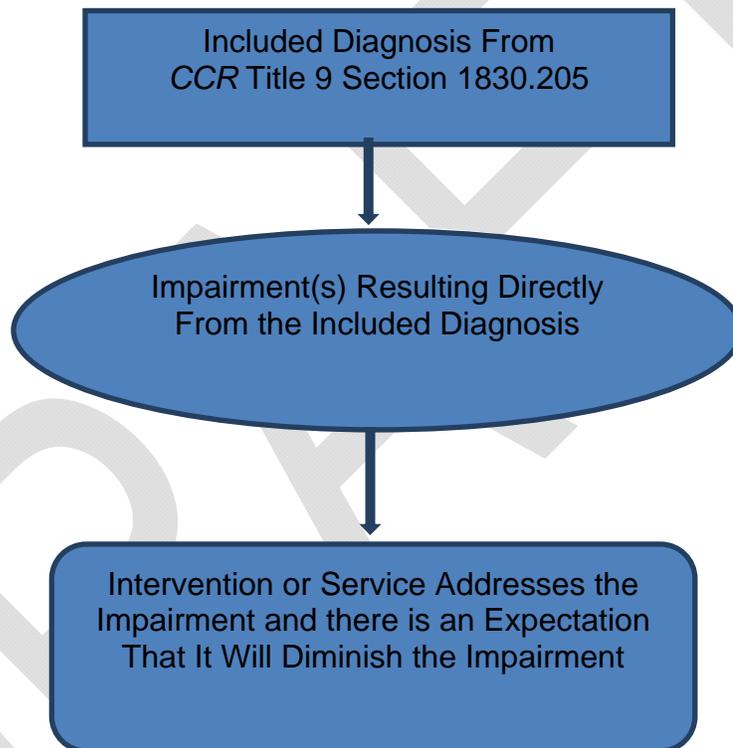
1. There must be an included diagnosis from CCR Title 9 Section 1820.205 (for beneficiaries receiving Inpatient Psychiatric service or PHF service) or section 1830.205(b) (1) for beneficiaries receiving all other SMHS.
2. The beneficiary must have one of the following impairments—and the qualifying impairment must be the **direct result** of the included diagnosis in #1 just above:
 - a. A significant impairment in an important area of life functioning;
 - b. A reasonable probability of significant deterioration in an important area of life functioning;
 - c. A reasonable probability a child will not progress developmentally as individually appropriate; or
 - d. Defects or mental illnesses or conditions which would not be responsive to physical health care based treatment.
3. The service or intervention must meet the intervention criteria in “a” and “b” (one of the four criteria in “b”) below:
 - a. The focus of the proposed intervention is to address the condition identified in #2 above; and
 - b. The expectation is that the proposed intervention or service:
 - i. Will significantly diminish the impairment; or
 - ii. Will prevent significant deterioration in an important area of life functioning; or
 - iii. Will allow the child to progress developmentally as individually appropriate; or
 - iv. Is necessary to correct or ameliorate defects and mental illness and conditions (if the beneficiary does not meet the medical necessity criteria in 1820.205 or 1830.205 but does meet the criteria in 1830.210).

Additional Guidance: Below are additional points of clarification regarding medical necessity criteria. The included diagnosis upon which eligibility for SMHS is based must be fully supported by the information contained in the beneficiary’s SMHS assessment.

Note that the list of included diagnoses for outpatient services (CCR Title 9 Section 1830.205) is different in some respects from the list of included diagnoses for inpatient services (CCR Title 9 Section 1820.205).

Note the interlocking nature of the criteria in #1 and #2 above: The impairment which is being addressed by the services for which Medi-Cal reimbursement is being sought must be the direct result of the included diagnosis.

The beneficiary should be consulted regarding what he/she would like to achieve from receiving mental health services. However, it is important to remember that it is necessary for the clinician to take the beneficiary's statement of goals or objectives and "translate" those into statements about impairments which result from the included diagnosis. The series of interlocking connections pictured below must be documented in order for the service to be reimbursable.



The expectation is that the proposed intervention or service will significantly diminish the impairment is evaluated according to whether there is a "reasonable probability" that the claimed intervention or service will diminish the impairment which is the object of treatment. "Reasonable probability" in turn is determined by the generally accepted community standard of care for that included diagnosis and that specific impairment.

Conceptualization of Medi-Cal SMHS Treatment

The planning and implementation of the delivery of mental health services should begin with a conceptualization of the overall treatment process for a particular client. The treatment process consists of three fundamental components: Client Assessment, Client Plan and Interventions.

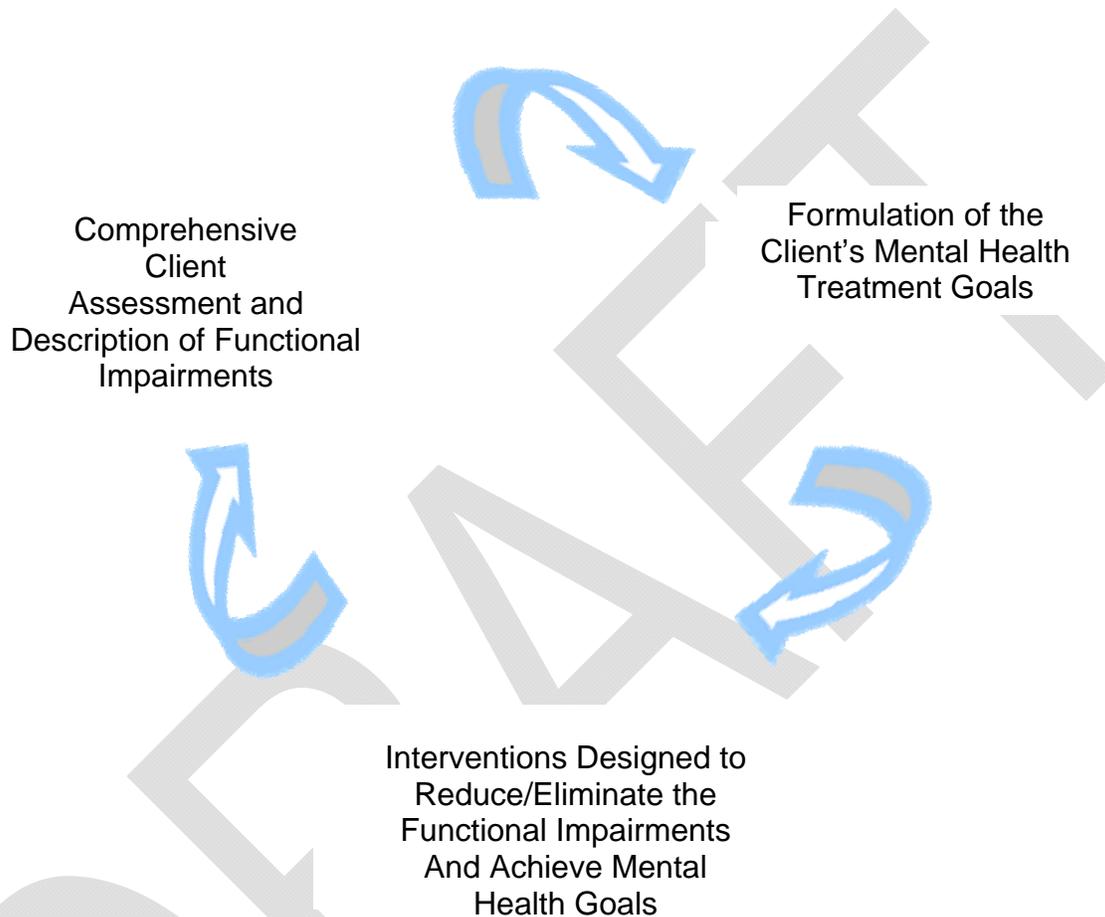
- 1) The mental health treatment process begins with a current comprehensive Client Assessment in which the current status of the beneficiary's mental status, physical, cultural and behavioral health information are documented. The assessment process documents the nature and extent of the mental health functional impairments currently being experienced by the beneficiary and the assignment of the five-axis diagnosis.
- 2) The Client Plan⁴ describes the overall structure and purpose of the mental health treatment to be provided to a beneficiary. The client plan identifies the interventions designed to reduce/eliminate/ameliorate the functional impairments and achieve the beneficiary's mental health goals.

The client plan should contain the following elements:

- Treatment goals that are behaviorally specific, quantifiable and time limited. Treatment goals should be directly linked to the impairments resulting from the included diagnosis.
 - Proposed types of interventions and their frequency and duration.
 - Description of the specific interventions to be provided to address each of the treatment goals. The interventions should focus and address the identified functional impairments resulting from the included diagnosis.
- 3) The progress notes document the interventions and the actual implementation of the client plan, as well as the beneficiary's responses to the treatment and interventions included in the client plan. The progress notes describe how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning as documented in the client plan. The progress notes document beneficiary encounters, including clinical decisions and interventions and relevant aspects of client care, including the documentation of medical necessity.

⁴ Please refer to the MHP Contract for required treatment plan elements.

The treatment process evolves as interventions lead to further assessments of the beneficiary's response to treatment and progress toward goals. This may lead to modifications of the treatment goals and changes in the selection of interventions to be used to achieve the identified mental health goals.



General Guidance Regarding Documentation Requirements

The following points provide general guidance regarding documentation of Specialty Mental Health Services (including ICC and IHBS):

- All chart documentation should be written in behaviorally specific language.
- The time claimed for a service should be commensurate with the service provided.
- Services provided solely for academic, vocational, recreational or socialization purposes are not reimbursable.
- Services which consist solely of transportation are not reimbursable.
- Services which are solely clerical in nature are not reimbursable.
- Services which are solely payee related are not reimbursable.
- Documenting missed appointments, or placing telephone calls to clients in an attempt to schedule appointments is not reimbursable.

- Writing discharge summaries is not a reimbursable service. Time spent by a provider with a client reviewing the course of treatment with a view to identifying what was accomplished, what remains to be done, etc. is reimbursable provided that documentation meets acceptable standards, but time spent alone by the provider in preparing an actual discharge summary is not.

Documentation Components

There are three primary documentation components: the Assessment, the Client Plan, and Progress Notes. The *minimum standards* specified for these three documentation components in the contract between DHCS and the MHPs are excerpted below:

Assessment

At a minimum, the Assessment should provide information in each of the following areas:

- Presenting Problem. The beneficiary's chief complaint, history of the presenting problem(s), including current level of functioning, relevant family history and current family information.
- Relevant conditions and psychosocial factors affecting the beneficiary's physical health and mental health; including, as applicable, living situation, daily activities, social support, cultural and linguistic factors, and history of trauma or exposure to trauma.
- Mental Health History. Previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions. If possible, include information from other sources of clinical data, such as previous mental health records, and relevant psychological testing or consultation reports.
- Medical History. Relevant physical health conditions reported by the beneficiary or a significant support person. Include name and address of current source of medical treatment. For children and adolescents: Include prenatal and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports.
- Medications. Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment. The assessment shall include documentation of the absence or presence of allergies or adverse reactions to medications, and documentation of an informed consent for medications.
- Substance Exposure/Substance Use. Past and present use of tobacco, alcohol, caffeine, complementary and alternative medications, and over-the-counter and illicit drugs.
- Client Strengths. Documentation of the beneficiary's strengths, including protective factors, in achieving client plan goals related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis.
- Risks. Situations that present a risk to the beneficiary and/or others, including past or current trauma.
- A mental status examination.
- A complete five-axis diagnosis from the most current DSM, or a diagnosis from the most current ICD codes shall be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data.
- Additional clarifying formulation information as needed.

Additional Guidance: All beneficiaries who receive any SMHS including ICC and IHBS must have an assessment that meets the above criteria and which is completed and/or signed off by

licensed/certified practitioner. This assessment is not a required ICC or IHBS intervention but if such an assessment is not completed, then all ICC/IHBS interventions (as well as other SMHS delivered) may be subject to disallowance. If an MHP/provider chooses to expand the required ICC comprehensive assessment to include these component they may do so.

Client Plans

Client Plans shall:

- Have specific observable and/or specific quantifiable goals/treatment objectives related to the beneficiary's mental health needs and functional impairments as a result of the [included] mental health diagnosis;
- Identify the proposed type(s) of intervention/modality including a detailed description of the intervention to be provided;
- Have interventions that focus and address the identified functional impairments as a result of the mental disorder;
- Have interventions that are consistent with the Client Plan goal;
- Be consistent with the qualifying diagnoses;
- Be signed (or electronic equivalent) by:
 - The person providing the service(s), or,
 - A person representing a team or program providing services, or
 - A person representing the [MHP] providing services, or
 - By one of the following as a co-signer, if the Client Plan is used to establish that services are provided under the direction of an approved category of staff, and if the signing staff is not of the approved category:
 - A physician,
 - A licensed/waivered psychologist,
 - A licensed, registered/waivered social worker,
 - A licensed/registered/waiver marriage and family therapist, or
 - A registered nurse including but not limited to nurse practitioners;
- Include documentation of the beneficiary's participation in and agreement with the Client Plan, as described in Title 9, CCR, Section 1810.440(c)(2)(A)(B).
 - Examples of acceptable documentation include, but are not limited to, reference to the beneficiary's participation and agreement in the body of the Plan, beneficiary signature on the Plan, or a description of the beneficiary's participation and agreement in the client record.
 - The beneficiary's signature or the signature of the beneficiary's legal representative is required on the Client Plan when:
 - The beneficiary is expected to be in long-term treatment as determined by the MHP and,
 - The Client Plan provides that the beneficiary will be receiving more than one type of Specialty Mental Health Service;
 - When the beneficiary's signature or the signature of the beneficiary's legal representative is required on the Client Plan and the beneficiary refuses or is unavailable for signature, the Client Plan shall include a written explanation of the refusal or unavailability.

- There shall be documentation in the beneficiary record that a copy of the Client Plan was offered to the beneficiary.

Additional Guidance: All beneficiaries who receive any SMHS including ICC and IHBS must have a client plan that meets the above criteria. The development of such a client plan is not a required ICC or IHBS intervention but if such client plan is not completed, then all ICC/IHBS interventions (as well as other SMHS delivered) may be subject to disallowance. If an MHP/provider chooses to expand the required ICC ICP to include these component they may do so.

Progress Notes

Progress Notes shall describe how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important are of life functioning outlined in the Client Plan. Items that shall be contained in the client record related to the beneficiary's progress in treatment include:

- Timely documentation of relevant aspects of beneficiary care, including documentation of medical necessity;
- Documentation of beneficiary encounters, including relevant clinical decisions, when decisions are made, [and] alternative approaches for future interventions;
- Interventions applied, [the] beneficiary's response to the interventions, and the location of the interventions;
- The date the services were provided;
- Documentation of referrals to community resources and other agencies, when appropriate;
- Documentation of follow-up care, or, as appropriate, a discharge summary;
- The amount of time taken to provide services; and
- The signature of the person providing the service (or electronic equivalent), the person's type of professional degree, and licensure or job title.

Guidelines for Development of the ICP

- Time spent reviewing records from other treatment facilities or child serving agencies is reimbursable if the information obtained is summarized in the client plan so that it can be shown to contribute to the development of the current client plan or the ICP.
- If more than one member of the CFT claims for participating in the ICC case management assessment process the specific role of each person participating and how they uniquely contributed to the process must be documented by each provider claiming payment for services.
- The CFT *“develops a child- and family-centered ICP which specifies the goals and actions needed to address the medical, educational, social, mental health, or other services needed by the youth and family.”* Participation in CFT for the purpose of developing the client plan or ICP, or monitoring or refining the plan with other significant support persons to assure the effectiveness of interventions toward the achievement of improved functioning in domains identified as actionable in the ICP, is reimbursable as long documentation fully describes the purpose and result of the service provided, consistent with Medi-Cal SMHS documentation requirements. If more than one provider is participating, the specific role and contribution of each provider claiming payment must be documented. Stated another way, meetings and case conferences are Medi-Cal reimbursable if they result in documentation that includes the

following points: (1) A behaviorally specific summary of the client's progress with respect to the Medi-Cal SMHS interventions and goals contained in or referenced in the Medi-Cal SMHS client plan and/or the ICP since the last CFT meeting or treatment conference; and (2) a clearly formulated decision to extend the current plan of care for a specific period of time or description of the modification to the Medi-Cal SMHS portion of the ICP. The Medi-Cal SMHS client or ICP must be in compliance with all of the requirements specified in the contract between DHCS and the MHPs for Client Plans.

If multiple mental health providers who are members of the CFT claim for participation in the development of the Medi-Cal SMHS client plan and ICP, the specific nature of the contribution made by each claimant must be carefully spelled out in the documentation in the Medi-Cal SMHS client plan and ICP. They may bill for time in plan development for collaboration that is helpful in the creation and monitoring of an effective client plan. Mental Health staff may bill for linkage/consultation with other members of the CFT when they provide support to those members by helping mitigate problem behaviors interfering with the successful achievement of goals.

Referral, Monitoring and Related Activities

In this area, the ICC provider *“will actively assist the youth and family in identifying, obtaining and monitoring the delivery of available services, including medical, educational, mental health, social, therapeutic or other services.”* Documentation of services must reflect how the referral, monitoring and related activities are intended to address the mental health needs of the child/youth, as identified in the client plan.

Transition

- Included under this heading is *“Developing with the CFT a transition plan when the youth has achieved goals outlined in the ICP.”* Planning for transition is an important part of care planning and starts from the point of initiation of service with the development of service goals in the CFT process. To the extent that some mental health impairments resulting from an included diagnosis are expected to remain beyond the provision of these intensive services, the source of continuing services delivered should be identified and consistent with the youth and families preferences and in place by the end of care.
- The second included activity under this heading is *“Collaborating with the other service providers and agencies on behalf of the youth and family.”* Documentation of collaboration must include how the activities were provided to benefit the treatment of the covered beneficiary's diagnosed mental health condition.

Documentation Guidelines and Examples for IHBS

Documentation of IHBS involves, documentation of the specific mental health interventions provided as designed to diminish impairment or ameliorate mental health conditions of the beneficiary. Documentation must include behaviorally specific descriptions of the problems being addressed (all of which should be on the ICP or a SMHS client plan unless they arise for the first time in the session being documented), the interventions performed, and the response(s) to the interventions.

In order to be Medi-Cal reimbursable, services must meet the criterion of “medically necessary” to diminish impairment or ameliorate mental health conditions. Documentation must reflect that the

service was provided specifically to meet the needs of the beneficiary as identified in the ICP and/or SMHS client plan, and not solely for the benefit of the caregiver, other members of the child's family, or other support persons. The following includes examples of what is required to address specific elements of the Core Practice Model and what the documentation must show:

Documentation of *“educating the child’s family about, and training the family in managing, the child’s disorder”* must clearly describe how the contact service the purpose of helping significant others in the client’s life implement the interventions outlined in the ICP or SMHS client plan.

- *“Improving self-care, including addressing behaviors and social skills deficits that interfere with daily living tasks and with avoiding exploitation by others”* must involve the teaching of skills to the beneficiary, including creating the opportunity to practice skills in real life settings rather than performing or assisting with the activities themselves.
- *“Improving self-management of symptoms, including assisting with self-administration of medications”* requires teaching (skill building, modeling, structured feedback, role playing, etc.) or other methods that result in increased functional self-management. Assisting, in and of itself, does not meet the medical necessity criterion for mental health intervention.

“Supporting the development and maintenance of social support networks and the use of community resources” documentation must describe exactly what the provider did and how this created a reasonable probability to diminishing impairment supported the achievement of a defined goal.

- *“Supporting employment objectives, by identifying and addressing behaviors that interfere with seeking and maintaining a job”* should describe how the interventions address behaviors that are the direct result of the included mental health diagnosis.
- *“Supporting educational objectives through identifying and addressing behaviors that interfere with succeeding in an academic program in the community”* is reimbursable if the behaviors are the direct result of the included mental health diagnosis. On the other hand, if the *“behaviors that interfere with succeeding in an academic program in the community”* are the direct result of a seizure disorder then this service activity would not be Medi-Cal reimbursable or considered medically necessary to ameliorate a mental health condition.
- *“Supporting independent living objectives by identifying and addressing behaviors that interfere with seeking and maintain housing and living independently”* is reimbursable if the *“behaviors that interfere with seeking and maintaining housing and living independently”* are the direct result of the included mental health diagnosis. For example, if a client is in treatment for Post-Traumatic Stress Disorder (PTSD) but the *“behaviors that interfere with seeking and maintaining housing and living independently”* are the direct result of substance abuse ,then this service activity would not be Medi-Cal reimbursable as a mental health service But if the client’s dual diagnosis is documented in the client plan which requires an integrated approach for the two conditions, this service can be Medi-Cal reimbursable, consistent with documentation requirements.

CHAPTER 4

PROVIDERS OF ICC AND IHBS

“Scope of Practice” is generally used to describe the experience, education and training of the provider of services that are restricted to a particular license category pursuant to California statutes, such as psychotherapy or medication support services. Scope of Practice is also used to indicate that provision of services must reflect the experience, education and training of every provider as specified in the Medi-Cal SMHS waiver and DHCS’ Medi-Cal State Plan Amendments (SPAs) for Rehabilitative and Targeted Case Management specialty mental health services. ICC and IHB Services (including care coordination) can be provided by individuals in any of the following professional or paraprofessional categories as approved by the MHP so long as they are working within their individual scope of practice.

The following provider categories are considered **Licensed Practitioners of the Healing Arts (LPHAs)** under the Medi-Cal SMHS waiver and DHCS’ Medi-Cal SPAs who can direct services and sign client plans:

- Physician
- Licensed or Registered/Waivered Clinical Social Worker
- Licensed or Registered/Waivered Marriage and Family Therapist
- Licensed or Waivered Psychologist
- Registered Nurse with a master’s degree in Psychiatric/Mental Health Nursing
- Registered Nurse (registered nurses may not conduct comprehensive assessments or make diagnoses (except nursing diagnoses).
- Certified Nurse Specialists

Pursuant to DHCS’ SPAs, all Medi-Cal specialty mental health services must be provided by or under the direction of one of the above LPHA’s.

“Under the direction of” means the LPHA is: i) directly providing the service; acting as a clinical team leader; or providing direct or functional supervision of service delivery; and ii) has reviewed, approved, and signed the client plan for those services within that are within that LPHA’s scope of practice. An individual directing a service is not required to be physically present at the service site to exercise direction. The LPHA directing a service assumes ultimate responsibility for the service provided.

Required Signatures on Client Plans: The client plan must have the signature of a LPHA.

The following additional providers may provide specific services within their authorized scope of practice under the direction of one of the above LPHAs upon approval of the MHP:

- Licensed Occupational Therapist
- Physician Assistant
- Licensed Vocational Nurse
- Psychiatric Technician
- Other Qualified Providers

DHCS' SPAs define "other qualified providers" as "individuals at least 18 years of age with a high school diploma or equivalent degree determined to be qualified to provide the service." The determination of qualification resides with the Mental Health Director or his/her designee, including requirements for co-signature in conjunction with an SMHS LPHA or other restrictions on scope of practice. Typically, "Other Qualified Providers" are defined (but not limited to) the following:

- Mental Health Rehabilitation Specialist (mental health related degree with experience as follows: MA plus 2 years' experience; BA plus 4 years' experience; AA plus 6 years' experience)
- Adjunct mental health staff, including Parent Partners/Peer Counselors and qualified mental health interns and trainees that do not meet any of the category qualifications described above may provide services, with evidence of on-going supervision, within the scope of the staff member's ability, as determined by the MHP. ICC and IHBS offer exceptional opportunities for Parent Partners/Peer Counselors who meet DHCS' SPA requirements as "Other Qualified Providers" to share a wealth of life experiences and/or training when they become part of the team working with families and youth in the sub-class.

CHAPTER 5

ADMINISTRATIVE GUIDELINES FOR ICC AND IHBS

For additional information concerning administrative guidelines and requirements for Medi-Cal claiming and reimbursement of ICC and IHBS, please see Addendum X. “MENTAL HEALTH SERVICES DIVISION (MHSD) INFORMATION NOTICE NO. 12-(To be determined).

A. Procedure Codes and Modifiers Used to Claim ICC and IHBS

ICC will be claimed by MHPs using procedure code “T1017” as for other Targeted Case Management (TCM) services, and be reimbursable at the TCM rate established for each MHP or subcontracting provider during each state fiscal year (SFY).

IHBS will be claimed by MHPs using procedure code “H2015” as for other mental health services (MHS) and be reimbursed at the MHS rates for procedure code “H2015” established for each MHP or subcontracting provider during each SFY.

ICC and IHBS will be distinguished from other TCM and MHS services by the use of procedure modifier “HK” for ICC and IHBS in place of the procedure modifier “HE” which is used for other TCM and MHS services.

B. Service Function Codes

Service Functions Codes for ICC and IHBS will be implemented in order for MHPs to separately identify both ICC and IHBS in their annual cost reports. Mode of Service 15 with Service Function Code 07 will be used for ICC and Mode of Service 15 with Service Code 57 will be used for IHBS.

C. Reimbursement Requirements for ICC and IHBS

- ICC may both be provided and reimbursed on the day of admission to psychiatric inpatient hospital, PHF or skilled nursing facility (SNF) in which the beneficiary is receiving Psychiatric Nursing Facility Services.
- The rendering provider (e.g. the individual who actually provides ICC or IHBS to the child or youth) must be legally employed by or legally under contract to the MHP, or one of the MHP’s contracted organizational providers.
- Employees or legal contractors to other county departments or public agencies (including probation, the court system, county social services, family agencies, public health, school districts or local education agencies, etc.) may not claim their services or time as ICC or IHBS.
- Contacts with significant support persons in the beneficiary’s life are claimable only if they are directed exclusively to the mental health needs of the beneficiary.
- When services are provided to or on behalf of a beneficiary by two or more persons at a single point in time, each person’s involvement must be documented in the context of the mental health needs of the beneficiary.

- It is anticipated that IHBS will for the most part be provided on a one to one basis. However, IHBS may be provided to two or more children and the services for all beneficiaries claimed to Medi-Cal: i) if more than one child in the home is receiving IHBS; ii) the impairment which is the focus of treatment includes a deficiency in the area of social skills such that skills remediation in that area might benefit from contact with another beneficiary; and iii) all of the children/youth receiving IHBS will benefit from the intervention because there is a reasonable chance that the intervention will reduce each child's impairment;

D. Claimable Units of Time

The claiming unit for ICC and IHBS will be the federal Health Insurance Portability and Accountability Act (HIPAA) standard unit of measurement which is 15 minutes of rendered service equaling one service unit. This is the standard unit of service for claiming all TCM and MHS services.

- As is done for claiming other TCM and MHS services – to calculate the standard claiming unit for ICC and IHBS, MHPs shall divide the total number of minutes of rendered service by 15 and claim the sum to two decimal places to DHCS. (E.G.: If a provider renders 37 minutes of ICC on a given date of service, for claiming purposes, the MHP shall divide 37 by 15 = 2.466667 units, and the MHP shall claim 2.47 units of service to DHCS).
- The exact number of minutes used by providers providing ICC and/or IHBS must be reported and used by the MHP to calculate the standard units of service to be claimed. In no case will more than 60 minutes be reported for any one provider during a one-hour period. In no case will the minutes reported or claimed for any one provider exceed the amount of actual time worked.
- When one person provides service to, or on behalf of, more than one beneficiary at the same time, the provider's time must be prorated to each beneficiary. When more than one provider provides a service to more than one beneficiary at the same time, the time spent by all providers providing the service must be added together to yield the total claimable minutes of service, divided by the total number of beneficiaries served, and then divided by 15 to calculate the number of reimbursable service units.
- The time required for documentation and travel (again the number of minutes divided by 15 to equal the number of service units) is reimbursable only when the documentation or travel is a component of a reimbursable service activity, whether or not the time is on the same day as the reimbursable service activity.

E. Other Medi-Cal SMHS that Can Be Provided with ICC and IHBS

- If determined to be medically necessary by the MHP, and if appropriately documented in the beneficiary's record/treatment plan/ICP, other Medi-Cal SMHS may be provided and reimbursed during the beneficiary's ICC/IHBS "treatment episode" as described below:
 - For up to 30 calendar days for a maximum of three non-consecutive periods of 30 calendar days or less per hospital or institutional stay prior to planned discharge, ICC may be provided during the same time period (e.g. on the same day) as psychiatric inpatient hospital, PHF and SNF (if the beneficiary is receiving Psychiatric Nursing Facility Services) if the ICC is directed towards placement activities that the 24-hour facility is not providing.

- ICC may be provided on the same day and during the same time period as Adult Residential Treatment Services and Crisis Residential Treatment Services for beneficiaries aged 18 until their 19th birthday through December 31, 2012 and effective January 1, 2013 aged 18 until their 20th birthday.
- ICC and IHBS may both be provided on the same day of service, though not during the same time period.
- ICC and IHBS may be provided on the same day though not during the same time period as the following additional Medi-Cal SMHS:
 - i. The Mental Health Services components of “Assessment”, “Plan development”, “therapy” and “collateral”
 - ii. Medication Support Services
 - iii. Crisis Intervention
 - iv. Crisis Stabilization

It should be noted that some Medi-Cal SMHS – including Therapeutic Behavioral Services (TBS), Targeted Case Management (TCM) and the MHS component of “Rehabilitation” within procedure code H2015 – may often duplicate the provision of ICC and IHBS to a Katie A. “sub-class” member. The obligation of county MHPs and subcontracting providers to not authorize or seek Medicaid FFP for duplicative services exists *independent* of any ability of the SD2 claiming system to detect circumstances which make services non-reimbursable. It remains critical for MHPs and their subcontracting providers to understand their oversight and monitoring responsibilities with regard to duplicative and non-reimbursable services during the time period in which beneficiaries receive ICC and IHBS. MHPs should monitor the utilization of ICC and IHBS closely to determine if the services are being delivered in an appropriate manner to Katie A. “sub-class” members and that ICC and IHBS are not duplicated by other Medi-Cal SMHS which have been claimed and reimbursed for the beneficiary for the same time period. MHPs are responsible to perform authorization, utilization management (UM) and utilization review (UR) activities and to maintain adequate medical records consistent with federal and state law to ensure that medical necessity criteria are met and that Medi-Cal SMHS services/claims are not duplicated.

DHCS may provide future guidance to MHPs regarding the process for UM, UR and authorization for ICC and IHBS in relation to other covered Medi-Cal SMHS in updates to this Documentation Manual or in the MHP contract.

F. IHBS Service “Lock-Outs”

The following Medi-Cal SMHS are not federal Medicaid reimbursable during the period in which the beneficiary receives IHBS:

- a) Day Treatment and Day Rehabilitation
- b) Psychiatric inpatient hospital, Psychiatric Health Facility (PHF) and Adult Crisis Residential services

Certain other factors must be considered in determining whether services are reimbursable. These include the purpose of the service (as described in much more detail in Chapter 3) and the site where the service is provided. (See Other Services that are Not Medi-Cal Reimbursable and Location “Lock-outs” below). A service is reimbursable only if its purpose is to: i) significantly diminish an impairment,

prevent significant deterioration in an important area of life functioning, allow the child/youth to progress developmentally as individually appropriate, or correct or ameliorate the defect resulting from the child/youth's Medi-Cal SMHS diagnosis(es); and ii) the service/intervention being billed directly addresses this impairment, deterioration in life functioning, or defect resulting from the child/youth's mental health diagnosis(es). Activities or interventions which do not meet both i) and ii) and which are not documented in the client plan are not reimbursable. See Chapter 3 of this Manual and relevant Appendices for Situational Examples for a detailed discussion of combinations of diagnoses, impairments/defects, services/interventions and documentation elements that are and are not reimbursable.

G. Services that are Not Medi-Cal Reimbursable

The following services are not Medi-Cal reimbursable since they are not eligible for federal financial participation (FFP).

- No service provided: Missed appointment
- Academic education services – actually teaching math or reading, etc.
- Vocational services that have as a purpose actual work or work training
- Recreation or general play
- Services provided are solely clerical (faxing, copying, calling to re-schedule appointment, etc.)
- Reviewing a chart for assignment of therapist, any documentation after the beneficiary is deceased, or preparing documents for court testimony
- Listening to or leaving voicemail or email messages
- Supervision of staff (including clinical internship, clinical hours, discipline, etc.). Supervision of clinical staff **is not** reimbursable. Reviewing and amending/updating the treatment plan with a supervisor **is** reimbursable.
- Service provided solely payee related
- Personal care services provided to beneficiaries. These include grooming, personal hygiene, assisting with medication, and meal preparation when performed for the child.
- Socialization, if it consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors of the beneficiaries involved.
- Medi-Cal program benefits that are excluded from coverage by the local MHP.
- Medi-Cal SMHS that are Minor Consent Services, if they are provided to a child whose eligibility is limited to Minor Consent Services.
- Solely transportation of an individual to or from a service.
- Translation or interpretive services including sign language.
- Services provided to beneficiaries who are in a non-hospital facility where the beneficiary is: i) an inmate serving time for a criminal offense; or ii) confined involuntarily in a state or federal prison, jail, detention facility, or other penal facility – (e.g. the beneficiary is an inmate of a public institution, as defined in Section 1905(a) (A) of the Social Security Act and Title 42, Code of Federal Regulations [CFR] Section 435.1009).
- Services provided to a beneficiary who is residing out-of-state at the time of service (unless s/he resides in a Medi-Cal recognized border community).
- Services provided to beneficiaries residing in an Institution for Mental Diseases (IMDs).
- Report writing (such as child abuse report). This includes mandated reporting such as CPS or APS reports.

- Any services provided by employees or contractors to any other public agency such as county probation, the county courts, county child welfare services, foster care or family agencies, school districts, local education agencies (LEAs), or special education programs.
- Any services provided:
 - For the convenience of the family, caregivers, physician or teacher.
 - To provide supervision or to ensure compliance with the terms and conditions of probation.
 - To ensure the child/youth's physical safety or the safety of others, e.g. suicide watch.
 - To address conditions that are not a part of the child/youth's Medi-Cal SMHS condition.

Many of these services may be reimbursable through other county mental health funding sources, such as counties' 1991 Local Realignment Funds, Mental Health Services Act (MHSA)/Proposition 63 Funds, or other public programs such as CWS wraparound programs, foster care or family programs, probation department or court programs, or special education/IEP programs.

H. Certification of Providers Who Can Render ICC and IHBS

For dates of service of January 1, 2013 through June 30, 2013, all MHP providers in the SD2 provider master file currently certified to claim for procedure code T1017 (e.g. Mode of Service 15, service function) and procedure code H2015 (e.g. Mode of Service 15, service functions __ - __) will automatically receive eligibility to claim for ICC and IHBS. Beginning with the next re-certification cycle for state fiscal year (SFY) 2013-14, county MHPs must submit to DHCS with their other provider certification documentation the certifications of those providers whom the MHP determines will be eligible to provide ICC (Mode of Service 15, Service Function 07) and IHBS (Mode of Service 15, Service Function 57).

I. Demonstration Project Identifier segment – “KATIE A. ICP”

Because it is necessary for MHPs and DHCS to track and report all Medi-Cal SMHS provided to Katie A. “sub-class” members for whom an ICP has been developed to the court, it is necessary to provide a mechanism in the SD2 system to distinguish all Medi-Cal SMHS provided to “sub-class” members from other claims. MHPs will identify all Medi-Cal SMHS claims provided to beneficiaries whom the MHP has certified as Katie A. “sub-class” members by using the Demonstration Project Identifier segment (Loop 2300 REF segment, with REF01 = “P4”) in either the 837P or 837I transaction set. The MHPs shall include “KATIE A. ICP” as the Demonstration Project Identifier (REF03).

Claims using this segment shall be: i) distinguished in SD2's internal database; ii) available when SD2 data is exported for reporting; and iii) distinguished when reported back to MHPs on an 835 transaction, so that counties can have certainty as to which of their claims DHCS has tracked as Katie A. claims.

Use of this identifier will allow MHPs and DHCs to do two things: i) track all Medi-Cal SMHS provided to Katie A. “sub-class” beneficiaries, not just ICC and IHBS; and ii) allow counties to claim and DHCS to track and report services which may already be meeting the criteria for ICC and IHBS. For example, some counties may already be, or may choose to, provide more expansive and collaborative specialty mental health case management and rehabilitation services which: a) formally incorporates family members, child welfare service providers, special education providers, and other

significant support persons into a team; and b) incorporates development of an ICP; through either TBS, existing AB 3632 services, or other SMHS service arrays. The Demonstration Project Identifier segment (Loop 2300 REF segment with REF01 = "P4") will allow counties to claim such services to DHCS as Katie A. services for beneficiaries certified under the Katie A. "sub-class"

J. ICC and IHBS Exemptions from Other Health Coverage (OHC) and Medi-Cal/Medicare (Medi-Medi) edits in SD2.

Claims for ICC and IHBS are exempt from the Other Health Coverage (OHC) and Medi-Cal/Medicare (Medi-Medi) edits in SD2. However, provision of ICC and IHBS does not exempt any other Medi-Cal SMHS provided to the same beneficiaries from the OHC and Medi-Medi edits if those other SMHS are otherwise subject to one or both edits. Use of the Demonstration Project Identifier per Paragraph I. above also does not exempt other Medi-Cal SMHS besides ICC and IHBS from the OHC and Medi-Medi edits if those other Medi-Cal SMHS are subject to these edits.

Addendum I

Medi-Cal Specialty Mental Health Services

Medi-Cal Specialty Mental Health Services (SMHS) are services provided to eligible Medi-Cal beneficiaries who meet medical necessity criteria. SMHS are the following services:

- Rehabilitative Mental Health Services
 - Mental Health Services
 - Assessment
 - Plan Development
 - Therapy
 - Rehabilitation
 - Collateral
 - Medication Support Services
 - Day Treatment Intensive
 - Day Rehabilitation
 - Crisis Intervention
 - Crisis Stabilization
 - Adult Residential Treatment Services
 - Crisis Residential Treatment Services
 - Psychiatric Health Facility Services
- Psychiatric Inpatient Hospital Services
- Targeted Case Management Services
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Specialty Mental Health Services

Rehabilitative Mental Health Services

Rehabilitative Mental Health Services are provided as part of a comprehensive specialty mental health services program available to Medicaid (Medi-Cal) beneficiaries that meet medical necessity criteria established by the State, based on the beneficiary's need for Rehabilitative Mental Health Services established by an assessment and documented in the client plan.

Rehabilitative Mental Health Services include the following:

1. Mental health services are individual, group or family-based interventions that are designed to provide reduction of the beneficiary's mental or emotional disability, restoration, improvement and/or preservation of individual and community functioning, and continued ability to remain in the community consistent with the goals of recovery, resiliency, learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive.

2. Medication support services include one or more of the following: prescribing, administering, dispensing and monitoring drug interactions and contraindications of psychiatric medications or biological that are necessary to alleviate the suffering and symptoms of mental illness. This service may also include assessing the appropriateness of reducing medication usage when clinically indicated. Medication Support Services are individually tailored to address the beneficiary's need and are provided by a consistent provider who has an established relationship with the beneficiary.
3. Day treatment intensive is a structured, multi-disciplinary program including community meetings, a therapeutic milieu, therapy, skill building groups, and adjunctive therapies, which provides services to a distinct group of individuals. It may also include rehabilitation, process groups and other interventions. Day treatment intensive is intended to provide an alternative to hospitalization, avoid placement in a more restrictive setting, or assist the beneficiary in living within a community setting. Services are available for at least three hours each day for half day services and for more than four hours for full day services. The Day Treatment Intensive program is a program that lasts less than 24 hours each day.
4. Day rehabilitation is a structured program including rehabilitation, skill building groups, process groups, and adjunctive therapies which provides services to a distinct group of individuals. It may also include therapy, and other interventions. Day rehabilitation is intended to improve or restore personal independence and functioning necessary to live in the community or prevent deterioration of personal independence consistent with the principles of learning and development. Services are available for at least three hours each day for half day services and for more than four hours for full day services. Day Rehabilitation is a program that lasts less than 24 hours each day.
5. Crisis intervention is an unplanned, expedited service, to or on behalf of a beneficiary to address a condition that requires more timely response than a regularly scheduled visit. Crisis intervention is an emergency response service enabling a beneficiary to cope with a crisis, while assisting the beneficiary in regaining their status as a functioning community member. The goal of crisis intervention is to stabilize an immediate crisis within a community or clinical treatment setting.
6. Crisis stabilization is an unplanned, expedited service lasting less than 24 hours, to or on behalf of a beneficiary to address an urgent condition requiring immediate attention that cannot be adequately or safely addressed in a community setting. The goal of crisis stabilization is to avoid the need for inpatient services which, if the condition and

symptoms are not treated, present an imminent threat to the beneficiary or others, or substantially increase the risk of the beneficiary becoming gravely disabled.

7. Adult residential treatment services are recovery focused rehabilitative services, provided in a non-institutional, residential setting, for beneficiaries who would be at risk of hospitalization or other institutional placement if they were not in the residential treatment program. The service includes a range of activities and services that support beneficiaries in their efforts to restore, improve, and/or preserve interpersonal and independent living skills and to access community support systems that support recovery and enhance resiliency. The service is available 24 hours a day, seven days a week and structured day and evening services are available all seven days.
8. Crisis residential treatment services are therapeutic or rehabilitative services provided in a non-institutional residential setting which provides a structured program (short term— 3 months or less) as an alternative to hospitalization for beneficiaries experiencing an acute psychiatric episode or crisis who do not have medical complications requiring nursing care. The service includes a range of activities and services that support beneficiaries in their efforts to restore, improve, and/or preserve interpersonal and independent living skills, and to access community support systems. The service is available 24 hours a day, seven days a week and structured day and evening services are available all seven days.
9. Psychiatric health facility services are therapeutic and/or rehabilitative services including one or more of the following: psychiatric, psychosocial, and counseling services, psychiatric nursing services, social services, and rehabilitation services provided in a psychiatric health facility. Psychiatric health facilities are licensed to provide acute inpatient psychiatric treatment to individuals with major mental disorders. Services are provided in a psychiatric health facility under a multidisciplinary model. Psychiatric health facilities may only admit and treat patients who have no physical illness or injury that would require treatment beyond what ordinarily could be treated on an outpatient basis.

A. Psychiatric Inpatient Hospital Services

Psychiatric inpatient hospital services are both acute psychiatric inpatient hospital services and administrative day services provided in a hospital. Acute psychiatric inpatient hospital services are those services provided by a hospital to beneficiaries for whom the facilities, services, and equipment are medically necessary for diagnosis or treatment of a mental disorder.

Administrative day services are psychiatric inpatient hospital services provided to a beneficiary who has been admitted to the hospital for acute psychiatric inpatient hospital services, and the beneficiary's stay at the hospital must be continued beyond the beneficiary's need for acute

psychiatric inpatient hospital services due to a temporary lack of residential placement options and non-acute residential treatment facilities that meet the needs of the beneficiary.

B. Targeted Case Management Services

Targeted Case Management Services are provided as part of a comprehensive specialty mental health services program available to Medi-Cal beneficiaries that meet medical necessity criteria based on the beneficiary's need for targeted case management established by an assessment and documented in the client plan. Targeted Case Management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, alcohol and drug treatment, social, educational and other services. Targeted Case Management includes a comprehensive assessment and periodic reassessment; development and periodic revision of a client plan; referral and related activities; monitoring and follow-up activities.

C. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

EPSDT supplemental services are mental health related diagnostic services and treatment, other than physical health care, available under the Medi-Cal program only to persons under 21 years of age pursuant to Title 42, Section 1396d(r), United State Code, that have been determined by the State Department of Health Care Services to meet the criteria of Title 22, Section 51340(e) (3) or (f); and that are not otherwise covered as specialty mental health services. EPSDT services include rehabilitative mental health services for seriously emotionally disturbed children: collateral, assessment, individual therapy, group therapy, medication service, crisis intervention, and day care intensive, day care habilitation offered in local and mental health clinics or in the community. EPSDT services include Therapeutic Behavioral Services for children/youth with serious emotional challenges.

Addendum II

Medical Necessity Criteria

§ 1830.205. Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services.

(a) The following medical necessity criteria determine Medi-Cal reimbursement for specialty mental health services that are the responsibility of the MHP under this Subchapter, except as specifically provided.

(b) The beneficiary must meet criteria outlined in Subsections (1)-(3) below to be eligible for services:

(1) Have one of the following diagnoses in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IVE, Fourth Edition (1994), published by the American Psychiatric Association:

- (A) Pervasive Developmental Disorders, except Autistic Disorders
- (B) Disruptive Behavior and Attention Deficit Disorders
- (C) Feeding and Eating Disorders of Infancy and Early Childhood
- (D) Elimination Disorders
- (E) Other Disorders of Infancy, Childhood, or Adolescence
- (F) Schizophrenia and other Psychotic Disorders, except Psychotic Disorders due to a General Medical Condition
- (G) Mood Disorders, except Mood Disorders due to a General Medical Condition
- (H) Anxiety Disorders, except Anxiety Disorders due to a General Medical Condition
- (I) Somatoform Disorders
- (J) Factitious Disorders
- (K) Dissociative Disorders
- (L) Paraphilias
- (M) Gender Identity Disorder
- (N) Eating Disorders
- (O) Impulse Control Disorders Not Elsewhere Classified
- (P) Adjustment Disorders
- (Q) Personality Disorders, excluding Antisocial Personality Disorder
- (R) Medication-Induced Movement Disorders related to other included diagnoses.

(2) Have at least one of the following impairments as a result of the mental disorder(s) listed in Subsection (b)(1) above:

- (A) A significant impairment in an important area of life functioning.
- (B) A reasonable probability of significant deterioration in an important area of life functioning.
- (C) Except as provided in Section 1830.210, a reasonable probability a child will not progress developmentally as individually appropriate. For the purpose of this Section, a child is a person under the age of 21 years.

(3) Meet each of the intervention criteria listed below:

(A) The focus of the proposed intervention is to address the condition identified in Subsection (b)(2) above.

(B) The expectation is that the proposed intervention will:

1. Significantly diminish the impairment, or
2. Prevent significant deterioration in an important area of life functioning, or
3. Except as provided in Section 1830.210, allow the child to progress developmentally as individually appropriate.
4. For a child who meets the criteria of Section 1830.210(1), meet the criteria of Section 1830.210(b) and (c).

(C) The condition would not be responsive to physical health care based treatment.

(c) When the requirements of this Section or Section 1830.210 are met, beneficiaries shall receive specialty mental health services for a diagnosis included in Subsection (b)(1) even if a diagnosis that is not included in Subsection (b)(1) is also present.

§ 1830.210. Medical Necessity Criteria for MHP Reimbursement for Specialty Mental Health Services for Eligible Beneficiaries Under 21 Years of Age.

(a) For beneficiaries under 21 years of age who are eligible for EPSDT supplemental specialty mental health services, and who do not meet the medical necessity requirements of Section 1830.205(b)(2)-(3), medical necessity criteria for specialty mental health services covered by this Subchapter shall be met when all of the following exist:

- (1) The beneficiary meets the diagnosis criteria in Section 1830.205(b)(1),
- (2) The beneficiary has a condition that would not be responsive to physical health care based treatment, and
- (3) The requirements of Title 22, Section 51340(e)(3)(A) are met with respect to the mental disorder; or, for targeted case management services, the service to which access is to be gained through case management is medically necessary for the beneficiary under Section 1830.205 or under Title 22, Section 51340(e)(3)(A) with respect to the mental disorder and the requirements of Title 22, Section 51340(f) are met.

(b) The MHP shall not approve a request for an EPSDT supplemental specialty mental health service under this Section or Section 1830.205 if the MHP determines that the service to be provided is accessible and available in an appropriate and timely manner as another specialty mental health service covered by this Subchapter and the MHP provides or arranges and pays for such a specialty mental health service.

(c) The MHP shall not approve a request for specialty mental health services under this Section in home and community based settings if the MHP determines that the total cost incurred by the Medi-Cal program for providing such services to the beneficiary is greater than the total cost to the Medi-Cal program in providing medically equivalent services at the beneficiary's otherwise appropriate institutional level of care, where medically equivalent services at the appropriate level are available in a timely manner, and the MHP provides or arranges and pays for the institutional level of care if the institutional level of care is covered by the MHP under Section 1810.345, or arranges for the institutional level of care, if the institutional level of care is not covered by the MHP under Section 1810.345. For the purpose of this Subsection, the determination of the availability of an appropriate institutional level of care shall be made in accordance with the stipulated settlement in *T.L. v. Belshe*.

Addendum III

Provider Qualifications

Minimum staff qualifications and provider scope of practice are based on state and federal Medi-Cal/Medicaid law, including California's SPA 10-12B for ICC providers and SPA 10-16 for IHBS providers. Following is a general description of the minimum staffing/provider qualifications and scope of practice for ICC and IHBS.

I. ICC and IHBS may be provided or directed by "Licensed Practitioner of the Healing Arts" (LPHA)

An LPHA possesses a valid California clinical licensure in one of the following professional categories:

1. Physician
2. Licensed Clinical Psychologist
3. Licensed Clinical Social Worker (LCSW)
4. Licensed Marriage and Family Therapist (MFT)
5. Registered Nurse with a master's degree in Psychiatric/Mental Health Nursing
6. Registered Nurse (RN) (RNs may not conduct comprehensive assessments or make diagnoses (except nursing diagnoses)
7. Certified Nurse Specialist (CNS)
8. Nurse Practitioners (NP)

An LPHA can:

- Function as a "head of Service" on agency application;
- Authorize, supervise and/or direct services as directed by the MHP
- Conduct comprehensive assessments and provide a diagnosis without co-signature (except for RN staff; check with local MHP);
- Co-sign the work of other staff members within their scope of practice; and
- Claim for all service categories within their scope of practice (example, a psychiatrist and RNs/CNSs/NPs can claim for medication support services, however, psychologists, LCSW's and MFTs cannot. Similarly, Registered Nurses may not assign mental health diagnoses or perform psychotherapy).

II. ICC and IHBS may be provided or directed by LPHA Waivered/Registered Professional

A waived/registered professional includes the following:

1. Registered Marriage and Family Therapist Interns/Associate Social Workers

Registered Marriage and Family Therapist Interns (MFT-Interns) and Associate Social Workers (ASWs) are individuals registered with the Board of Behavioral Sciences in order to obtain supervised clinical hours and acquire clinical

experience towards licensure as a MFT and LCSW, respectively. The oversight for Registered MFT-Interns and ASWs is monitored by the MHP.

Waivered Psychologist, MFT-Interns and ASWs may perform the following activities under the supervision of an LPHA within their scope of practice:

- Function as an LPHA staff for the time dictated by the MHP or DHCS. (Note: As described above, Registered Psychologists/Psychological Assistants are granted their waiver term by DHCS. MFT-Interns and ASWs are overseen and monitored by the MHP).
- Authorize, supervise or direct services as directed by the MHP.
- Conduct comprehensive assessments and provide a diagnosis without co-signature while under waiver;
- Co-sign the work of other staff members within their scope of practice other than another graduate student performing therapy;
- Claim for ICC and IHBS as well as all other Medi-Cal SMHS mental health services, Unplanned Services and TCM within their scope of practice. (Registered Psychologists/Psychological Assistants, MFT-Interns and ASWs cannot claim for medication support services).

Waivered Psychologist, MFT-Interns and ASWs cannot:

- Function as the Head of Service unless they meet qualifications dictated by the California Code of Regulations.
- Hold themselves out as independent practitioners and claim as an Enrolled Network Provider.

III. ICC and IHBS may be provided by a Mental Health Rehabilitation Specialist (MHRS)

An MHRS meets one of the following requirements:

- 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.

MHRS staff can perform the following activities:

- Function as “Head of Service” on agency/provider applications as determined by the MHP (note: MHRS’s do not qualify as a “Director of Mental Health Services” unless approved by DHCS);
- Provide and collect information for assessments; and
- Claim for all Mental Health Services (except Therapy), Unplanned Services, and TCM within their scope of practice.

MHRS staff cannot:

- Authorize, supervise or direct services.
- Co-sign the work of other staff members
- Perform the Mental Health Status Examination, assign the five-axis diagnosis, develop the medication plan, or perform psychotherapy.

IV. ICC and IHBS may be provided by Adjunct Mental Health Staff including Parent Partners/Peer Counselors and Other Staff Not Meeting the Above Categories I. – IV.

The MHP has the prerogative and program flexibility to integrate and define other staff that can provide ICC and IHBS.

Adjunct mental health staff and other staff not meeting any of the category qualifications described in Sections I – IV above, including Parent Partnership/Peer Counselors:

- May provide services, with evidence of on-going supervision, within the scope of the staff member's ability, as directed by the MHP.

Adjunct mental health staff and other staff not meeting any of the category qualifications described in Sections I – IV above cannot:

- Function as a “head of service” on an agency application.
- Authorize, supervise or direct services.
- Co-sign the work of other staff members
- Perform the Mental Health Status Examination, assign the five-axis diagnosis, develop the medication plan, or perform psychotherapy.