COUNTY OF SANTA CLARA
Behavioral Health Services

ICC and IHBS Screening and Service Request Form Information Guide

Corresponds with "ICC and IHBS Screening and Service Request Form – November 2023"

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Background and Overview

The County of Santa Clara (CSC) Behavioral Health Services Department (BHSD) is implementing a policy for Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) for County and County Contracted Providers (CCPs) across the Children, Youth and Family (CYF) System of Care. As part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits, ICC and IHBS must be provided to eligible beneficiaries who are under age 21 with full scope Medi-Cal and meet the Medical Necessity criteria. The BHSD ICC and IHBS policy provides guidance on the determination of eligibility, need and request for ICC and IHBS services. The implementation of this policy begins on January 1, 2024.

Purpose

This information guide serves a resource for County and CCPs by describing the ICC and IHBS processes and the use of the "*ICC and IHBS Screening and Service Request Form*".

ICC Screening

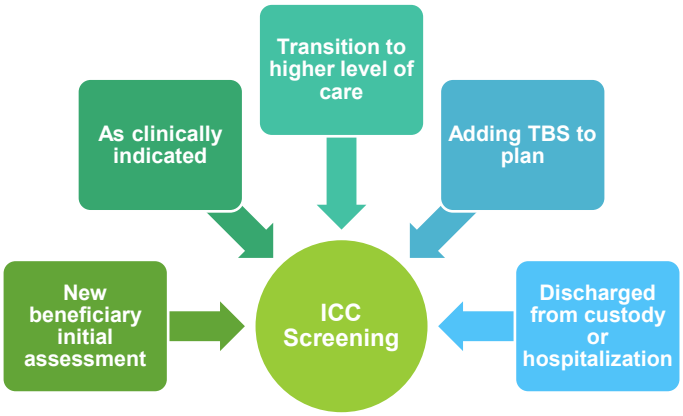
All eligible beneficiaries under age 21 with full-scope Medi-Cal must be screened for ICC service needs using the standardized form developed by CSC BHSD CYF.

When to screen?

New beneficiaries will be screened for ICC as part of the initial assessment process to establish care.

Current beneficiaries will be screened for ICC as clinically indicated for changes in service needs or when any of the following events occur:

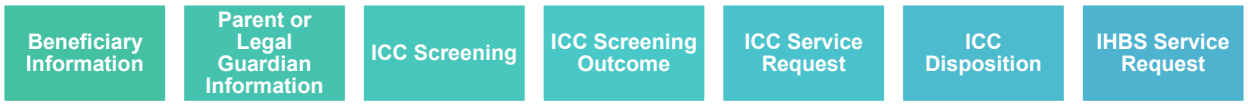
1. A beneficiary is being transitioned to a higher level of care.
2. A beneficiary is being discharged from hospitalization or custody.
3. Therapeutic Behavioral Services is being added to a beneficiary's treatment plan.



Screening and Service Request Form

A single form was developed to include ICC and IHBS related processes. Service providers are required to use the standardized form to screen and request for ICC and IHBS services.

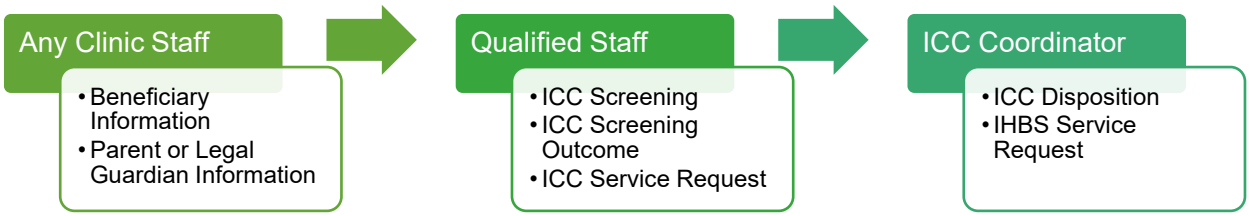
Main Sections of Form



Who can fill out the form?

The individual to complete the standardized form will vary depending on the form section. While any clinic staff can fill out the first two form sections (*Beneficiary Information, Parent or Legal Guardian Information*), the remainder of the form must be completed by designated staff.

Given that ICC screenings must be conducted by a professional or paraprofessional on the clinical team, only these individuals are qualified to complete the *ICC Screening, ICC Screening Outcome, ICC Service Request* sections on the form. ICC Coordinators receiving and reviewing ICC service requests will complete *ICC Disposition*. When IHBS needs are identified, ICC Coordinators will also complete *IHBS Service Request* and follow the authorization request process.



Intensive Care Coordination (ICC)

Form Section: ICC Screening

The *ICC Screening* section has two components: (1) administrative information; and (2) criteria questions. The first component captures when, who, where, and type of ICC screening being conducted.

ICC Screening Administrative Information

1. To begin, enter administrative information of screening being conducted.

Form Fields	Descriptions and/or Instructions
Screening Date	Enter date of ICC screening being conducted
Screening Conducted By	Enter name of individual who conducting ICC screening
Screening Program, Agency & Location	Enter program name, agency name and location of where ICC screening is being conducted. *Location is needed for agencies with more than one location.*
Screening Type	Select screening type based on reason for screening
Initial Evaluation	This screening is for a beneficiary new to the service provider; or this is the first ICC screening being conducted for this beneficiary at the agency.
Re-evaluation	This is a subsequent screening for a beneficiary. Indicate reason for the re-evaluation.

ICC Screening Criteria Questions
The criteria questions assess beneficiary's needs for ICC services. ICC need is established when "Yes" is determined for all 3 criteria questions.

The first two questions affirm that the beneficiary:

1. Has full scope Medi-Cal.
2. Meets Medical Necessity criteria for ICC services.

The third question includes a list of recommended indicators for ICC services. The individual conducting the ICC screening must review the indicator list and mark the corresponding checkbox when the condition applies to the beneficiary. A "Yes" response to question #3 requires one marked checkbox at minimum.

3. Meets at least one of the recommended indicators for ICC services.

ICC Screening Indicators
The following table describes each recommended indicator and the conditions for marking the checkbox.

Indicators	Definitions (mark checkbox if…)
☐ Involved with two or more supportive services from child-serving systems	The beneficiary is in child welfare, is juvenile justice involved, or receiving special education, developmental (SARC), and/or specialized medical services.
☐ Receiving or being considered for Wraparound	The beneficiary is currently receiving Wraparound or is eligible for Wraparound (DFCS and Juvenile Justice involved).
☐ Being considered for intensive specialty mental health services (SMHS) or currently receiving crisis stabilization or intervention services	The beneficiary is being considered for intensive SMHS, including but not limited to Therapeutic Behavioral Services (TBS) or receiving crisis stabilization or intervention services.
☐ Currently in or being considered for Short Term Residential Therapeutic Programs (STRTPs)	The beneficiary is currently in or being considered for a Short Term Residential Therapeutic Program (STRTP).
☐ Discharged within 90 days from or currently being treated at a Psychiatric Hospital or Crisis Stabilization Unit (CSU)	The beneficiary was hospitalized and discharged in the past 90 days from a psychiatric hospital or Crisis Stabilization Unit, or currently being treated at a psychiatric hospital or Crisis Stabilization Unit. Examples of psychiatric hospital: Fremont Hospital, San Jose Behavioral Health, John Muir, etc.
☐ Experienced two or more mental health hospitalizations in last 12 months	The beneficiary was hospitalized at a psychiatric facility for mental health reasons two or more times in the last 12 months.
☐ Experienced two or more placement or placement changes within 24 months due to behavioral health needs	Within the last 24 months, the beneficiary has had two or more formal out-of-home placements, or two or more placement changes due to behavioral health needs. Exclude informal family arrangements.

☐ Treated with two or more antipsychotic medications at the same time over a three (3) month period	The beneficiary has been taking two or more antipsychotic medications simultaneously for full three months.
☐ Had two or more crisis encounters within the last six (6) months due to behavioral health concerns	The beneficiary had two or more crisis encounters due to any mental health condition within the last six months, (e.g., Mobile Crisis, Emergency Room, Emergency Psychiatric Services, Crisis Stabilization Unit, Behavioral Health Urgent Care) May include but not limited to 5150 holds.
☐ Currently receiving SMHS and experiencing housing insecurity	The beneficiary is in SMHS and experiencing housing instability (at risk of losing housing, or currently unhoused).

The age specific indicators are also part of Criteria Question #3. These are indicators based on the age of the beneficiary at the time of screening.

Age Specific Indicators	**Definition (mark checkbox if…)**
☐ (Age 0-5) Treated with more than one (1+) psychotropic medication	The beneficiary is being treated with more than one psychotropic medication.
☐ (Age 0-5) Diagnosed with more than one (1+) mental health diagnosis	The beneficiary is diagnosed with more than one mental health diagnoses.
☐ (Age 6-11) Treated with more than two (2+) psychotropic medications	The beneficiary is being treated with more than two psychotropic medications.
☐ (Age 6-11) Diagnosed with more than two (2+) mental health diagnoses	The beneficiary is diagnosed with more than two mental health diagnoses.
☐ (Age 12-17) Treated with more than three (3+) psychotropic medications	The beneficiary is being treated with more than three psychotropic medications.
☐ (Age 12-17) Diagnosed with more than three (3+) mental health diagnoses	The beneficiary is diagnosed with more than three mental health diagnoses.

Form Section: ICC Screening Outcome

The *ICC Screening Outcome* section must be completed according to responses entered in *ICC Screening* section.

Responses to *ICC Screening* criteria questions	**Procedures**
If "Yes" to all 3 criteria questions: the beneficiary meets criteria for ICC.	1. Under "Needing services?", mark option "Yes, criteria met". 2. Describe and offer services to the beneficiary and family. Under "Offered services", I. Mark option "Yes, offered" when beneficiary and family are offered the services. II. Mark option "No, not offered" if beneficiary and family was not offered services. i. Indicate in notes the reasons for not offering services. 3. If offered services, ask beneficiary and family about accepting ICC services. Under "Accepted services", I. Mark option "Yes, accepted" when beneficiary and family agree to services. II. Mark option "No, declined" if beneficiary and family decline services. 4. <u>For beneficiaries already in ICC and being re-evaluated:</u> indicate under "Continuing services?" whether the beneficiary will continue or discontinue ICC services. 5. <u>For beneficiaries in need of and agreed to ICC services:</u> proceed to request ICC services for beneficiary.
If "No" to at least one criteria question: the beneficiary does not meet criteria for ICC.	1. Under "Needing services?", mark option "No, criteria not met". 2. Conclude ICC screening and document appropriately.

All forms pertaining to ICC screening, whether the beneficiary is eligible for and accepts ICC services or not, must be retained for auditing purposes.

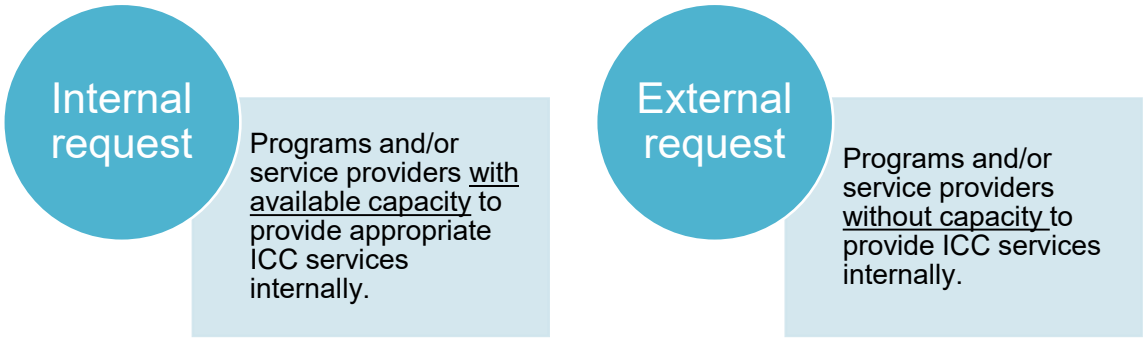
Form Section: ICC Service Request

The *ICC Service Request* section must be completed in order to request ICC services regardless of internal vs. external request type. *Refer to definitions below.*

1. To begin, enter administrative and contact information of requestor and requesting program and agency.

Form Fields	Descriptions and/or Instructions
Request Date	Enter date of ICC service request
Requesting Program & Agency	Enter program name, agency name and location of where ICC service is being requested. *Location is needed for agencies with more than one location.*
Request Made By	Enter name of individual who is completing the request
Email Address	Enter email address of the requestor
Phone Number	Enter phone number of the requestor
Fax Number	Enter fax number of the requestor

2. For "Request Type": Determine whether an internal or external request is needed. Refer to *ICC Service Request Type Diagram* for additional details.



3. Must follow the appropriate process for ICC service request.
   a. Internal request: Submit to designated ICC coordinator within own program or agency according to internal procedures.
   b. External request: Follow current transfer process to identify available ICC services from an external agency for the beneficiary. The service request will then be shared with the ICC Coordinator at the agency providing ICC services.

Form Section: ICC Disposition

Upon reviewing information completed in ICC screening and request related sections and determining ICC services could be provided to the beneficiary, the ICC Coordinator will complete the *ICC Disposition* form section.

1. To begin, enter administrative and contact information of reviewing ICC Coordinator.

Form Fields	Descriptions and/or Instructions
Request Received Date	Enter date of ICC service request was received by ICC Coordinator
Request Accepted Date	Enter date of ICC service request was accepted by ICC Coordinator
Request Reviewed By	Enter name of ICC Coordinator who is reviewing the request
Email Address	Enter email address of ICC Coordinator
Phone Number	Enter phone number of ICC Coordinator
Fax Number	Enter fax number of ICC Coordinator

2. For "Program & Agency Assigned": Indicate the name of the program and agency to provide ICC services to the beneficiary.
    a. Mark 'same as requesting program and agency' if the requesting program and agency is the same as the providing program and agency.

3. For "ICC Coordinator Assigned": Indicate the name of the ICC Coordinator assigned to the beneficiary.
    a. Mark 'same as service request reviewer' if the individual reviewing the ICC service request will also serve as the beneficiary's ICC Coordinator.

4. For "ICC being added as adjunct": ICC may be added as an adjunct with identified specialty programs and dependent on the circumstance of the beneficiary, such as short-term stabilization services.
    a. Mark "ICC being added as adjunct" if ICC services will be provided to the beneficiary as an adjunct service.

Intensive Home Based Services (IHBS)

As part of ICC services, the ICC Coordinator will facilitate the process of establishing a Child and Family Team (CFT) for the beneficiary. The CFT will develop an individualized treatment plan for the beneficiary and determine the beneficiary's need for IHBS.

Note: For beneficiaries who are in foster care, the CFT must also determine the beneficiary's need for Therapeutic Foster Care (TFC).

Form Section: IHBS Service Request

When IHBS is appropriate and agreed upon by the beneficiary and family, the ICC Coordinator will proceed with submitting an IHBS service request. To submit the service request, the ICC Coordinator will add to the "ICC and IHBS Screening and Service Request Form" with the most recent ICC related sections completed. The BHSD Utilization Management (UM) authorization request process must also be followed to request IHBS.

ICC and IHBS Screening and Service Request Form

1. To begin the 'IHBS Service Request' form section, enter administrative information regarding the IHBS service request.

Form Fields	Descriptions and/or Instructions
Request Date	Enter date of IHBS service request
Request Completed By	Enter name of ICC Coordinator who is completing the request
Start Date of ICC Services	Enter date ICC Services was initiated for the beneficiary
Date of IHBS Need Identified by CFT	Enter date CFT determined IHBS is needed for the beneficiary
Date of Most Recent CFT Meeting	Enter date of the most recent CFT meeting for the beneficiary
Request Type	The standardized form is for new authorization requests only. New: The request is for a new authorization. The beneficiary is currently not receiving IHBS services. *Note for continuing/reauthorization*: Follow BHSD UM procedures for reauthorization requests.

2. Indicate justification for IHBS request by selecting appropriate conditions from the checklist. Describe other justification if necessary.

☐ Functional impairment (challenges with functioning in the home and/or community)
- ☐ Developmental impairment (challenges with developmental progress)
- ☐ Social impairment (challenges with interaction with others)
- ☐ Probable significant deterioration (deterioration at home and/or community)
- ☐ Family instability (interference with having a stable and permanent family life)
- ☐ Housing instability (interference with maintaining housing)
- ☐ Educational challenges (interference with educational achievement)
- ☐ Employment instability (interference with seeking and maintaining a job)

☐ Other, please describe:

3. In the following text box, list mental health diagnosis and provide narrative of the beneficiary's treatment plan goals and how IHBS will benefit the beneficiary.

4. Provide additional information to indicate plan and agreement for IHBS services.
   a. 'Is an individualized treatment plan in place for the beneficiary?': There should be an individualized treatment plan developed for the beneficiary as part of ICC services.
      i. If not, an individualized treatment plan must be in place for first before requesting for IHBS.

b. ‘Was IHBS agreed upon and accepted by the beneficiary and family?’: The beneficiary and family must agree to receiving IHBS.
    i. If not, IHBS would not be provided.

c. ‘Where will IHBS be delivered to beneficiary?’: Indicate which setting IHBS will be delivered to the beneficiary.

5. A Licensed Practitioner of the Healing Arts (LPHA) from the program: Provide attestation that the beneficiary meets medical necessity criteria.
    a. Mark checkbox of statement: “I attest that IHBS is a medically necessary service for this beneficiary.”
    b. Name of LPHA who reviewed the request and is providing attestation
    c. Signature of LPHA
    d. Date of LPHA attestation and signature

6. Date of IHBS Service Request Sent to BHSD UM: indicate date of when the IHBS service request was submitted to BHSD UM.

IHBS Service Request to BHSD Utilization Management (UM)

In addition to completing the IHBS Service Request form section, the ICC Coordinator must also complete the CSC BHSD UM authorization request form. BHSD UM can be contacted at BHSDUM@hhs.sccgov.org.

1. Submit required documents and information to BHSD UM for IHBS review and authorization.
    I. CSC BHSD UM Authorization Form
    II. ICC and IHBS Screening and Service Request Form
    III. Other required information as indicated by BHSD UM

Upon review, BHSD UM will notify the requesting service provider of authorization decision. Authorization requests must be submitted and approved prior to the start of IHBS services. No retroactive requests will be accepted.

Reauthorization Request

If a beneficiary requires extended IHBS services beyond the initial authorized period, the ICC Coordinator must submit a reauthorization request to UM. Reauthorization requests must be submitted following the timeframe indicated by the BHSD UM authorization policy.

1. Submit required documents and information to BHSD UM for IHBS reauthorization.
    I. CSC BHSD UM Authorization Form
    II. Other required information as indicated by BHSD UM

While it is not required to complete the ICC and IHBS Screening and Service Request form for the reauthorization requests, a justification for extended services and evidence of meeting medical necessary criteria must be provided. Similar to initial authorization requests, BHSD UM will notify the requesting service provider of reauthorization decision. Reauthorization requests must be approved prior to extending IHBS services.