SANTA CLARA COUNTY
Behavioral Health Services

Supporting Wellness and Recovery

Santa Clara County
Behavioral Health Services Department
INPATIENT OPERATIONS HANDBOOK

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1. BHSD REFERENCES

REFERENCES:

- 42 CFR § 438.10. Information requirements.
- 42 CFR § 438.210. Coverage and authorization of services.
- 42 CFR § 438.404. Timely and adequate notice of adverse benefit determination.
- 42 CFR § 438.910. Parity requirements for financial requirements and treatment limitations.
- 42 CFR §§ 456.1- 456.575. Utilization Control
- 81 CFR, §27497. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability
- 9 CCR §§590-594. Utilization Review of Short-Doyle Funded Acute Inpatient Psychiatric Services
- 9 CCR §§ 1820.100 - 1820.230. Medi-Cal Psychiatric Inpatient Hospital Services
- 9 CCR §§ 1840.205-1840.215. Psychiatric Inpatient Hospital Services
- 9 CCR §1810.242. Receipt or Date of Receipt
- 9 CCR §1820.220. MHP Payment Authorization by a Point of Authorization.
- 9 CCR §1820.205. Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient Hospital Services.
- 9 CCR §1820.230. MHP Payment Authorization by a Utilization Review Committee.
- 9 CCR §1850.305. General Provisions.
- HSC § 1367.01. Health Care Service Plans
- HSC, § 1371.4. Emergency Medical Condition and Post-Stabilization Responsibilities for Medically Necessary Health Care Services
- WIC § 14197.1. Covered mental health benefits and substance use disorder benefits, compliance with federal law
- MHSUDS Information Notice 17-040. Chart Documentation Requirement Clarifications
- MHSUDS Information Notice 19-026. Authorization of Specialty Mental Health Services.
- MHSUDS Information Notice 20-008. County responsibility to pay for acute psychiatric inpatient hospital services provided in an institution for mental disease (IMD) and clarification about funding sources for patients in IMD no longer requiring an inpatient level of care.
- BHSD Policy #415-001 Network Adequacy and Timely Access
- BHSD Policy #415-002 Advance Directives
- BHSD Policy #415-006 Provider Beneficiary Communication
- BHSD Policy #415-101 Medical Necessity
- BHSD Policy #415-301 Cost Sharing and Payment of Services
- BHSD Policy #415-405 Provider Network Enrollment, Screening, Selection and Retention

- BHSD Policy #415-406 LPS Facility Designation, Redesignation and Reporting Requirements
- BHSD Policy #415-803 Utilization Management Program
- BHSD Policy #415-805 Beneficiary Problem Resolution Process
- BHSD Policy 415-807 Quality of Care Reporting, Review, and Investigation
- BHSD Policy #415-808 Non-Discrimination Auxiliary and Language Assistance Services.
- BHSD Policy #415-811 UM Treatment Authorization Request for Mental Health Stay in Hospital
- BHSD Policy #415-815 Beneficiary Rights
- BHSD Policy #415-819 Grievance and Appeal Oversight Process
- BHSD Policy #415-820 Notice of Adverse Benefit Determination
- BHSD Policy #415-902 Out of Plan Services
- BHSD Policy #415-903 Emergency and Post Stabilization Services
- BHSD Policy #415-904 Care Coordination and Continuity of Care

2. OVERVIEW

This Inpatient Operations Handbook is designed to provide inpatient psychiatric facilities with information related to the provision of Fee for Service (FFS) and Managed Care Plan (MCP) for Medi-Cal beneficiaries as well as use of county general funds for qualifying patients who are residents of Santa Clara County. This handbook includes both Children Youth and Families (CYF) resources (Appendix 6A) and Adult Older Adult (AOA) resources (Appendix 6B).

This manual includes information on emergency services, and acute psychiatric inpatient services for Medi-Cal and specific unsponsored patients. Please note that contracted providers are governed by the requirements of 9 CCR§ 1820.100-§ 1830.535 Medi-Cal Psychiatric Inpatient Hospital Services.

MHSUDS Information Notice #19-026 Authorization of Specialty Mental Health Services requires DHCS to ensure Medi-Cal mental health benefits are provided in compliance with the federal mental health parity regulations. Subdivision (b) authorizes the department to implement and interpret WIC § 14197.1 by information notice. The Department is implementing WIC § 14197.1 by requiring Mental Health Plans to perform concurrent reviews of inpatient psychiatric hospital services, Crisis Residential Treatment Services and Adult Residential Treatment Services.

DHCS is currently drafting guidelines to help MHP's transition from retrospective to concurrent review processes. BHSD currently conducts retrospective reviews and will update this manual when the state provides concurrent review guidance.

When BHSD moves toward concurrent review, inpatient facilities will be required to provide notice of hospitalization within 24 hours of admission. BHSD will make an initial authorization determination within two days of receipt of hospital notification. Payment will be contingent on documentation demonstrating the patient meets and continues to meet medical necessity criteria as outlined in 9 CCR §1820.205. Decisions to approve, modify, or deny provider requests for authorization concurrent with the provision of SMHS to beneficiaries shall be communicated to the beneficiary's' treating providers, including both the hospital, and treating physician, in writing, within 24 hours of the decision. If the MHP denies or modifies the request for authorization, the MHP must notify the beneficiary, in writing, of the adverse benefit determination. In the case of concurrent review, care shall not be discontinued until the beneficiary's treating provider(s) has been notified of the MHP's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the beneficiary.34 In cases where the MHP determines it will terminate, modify, or reduce services, the MHP must notify the beneficiary, in writing, of the adverse benefit determination prior to discontinuing services.

This manual is available to all inpatient acute care psychiatric providers who provide services to qualifying Santa Clara County residents. The manual is intended to establish guidelines for the partnership between BHSD, contracted and private providers. Although critical, inpatient psychiatric care is but a component in a large continuum of mental health service. BHSD aims to provide a seamless, cost-effective array of services for patients that will achieve desired outcomes.

3. INTRODUCTION

Behavioral Health Services Department (BHSD) is the State of California's Local Mental Health Plan (LMHP) for Santa Clara County. BHSD is responsible for administering all Medicaid/Medi-Cal, State grant and other funds for mental health services through a well-managed system that is designed to ensure available, accessible, and quality mental health care for eligible Medi-Cal beneficiaries.

BHSD conducts retrospective reviews for inpatient psychiatric facilities for inpatient services provided to Santa Clara County residents. The State of California Department of Health Care Services (DHCS) has approved the process of retrospective reviews of requests for authorizing reimbursement for Medi-Cal inpatient psychiatric services provided to Medi-Cal eligible beneficiaries of Santa Clara County.

A. Contract Provider Hospitals

The bulk of the information contained within this manual applies to inpatient psychiatric facilities that have a contract with BHSD.

B. Non-Contract Hospital Providers

Fee for Service Medi-Cal Hospitals – That have the ability to bill the state Fiscal Intermediary directly for patient emergency psychiatric services must provide a Notice of Hospitalization for Medi-Cal Beneficiaries to BHSD within ten (10) days of admit.

Fee for Service Medi-Cal Hospitals – That do not have the ability to bill the state fiscal intermediary for patient emergency psychiatric services due to an excluded age range must obtain an authorization from the appropriate Hospital Liaison.

Free-standing Psychiatric Facilities – With no contract with BHSD and no ability to bill the state fiscal intermediary directly must obtain authorization from the appropriate Hospital Liaison.

4. BHSD CONTACT POINTS

There are four distinct methods of contact that relate to the specific situation.

A. Emergency Psychiatric Services (EPS) Transfer

EPS accepts transfers of patients from medical acute care facilities and emergency rooms in compliance with applicable laws and regulations, including the Emergency Medical Treatment and Active Labor Act (EMTALA). All transfers must be approved and accepted by an Acute Psychiatric Services Physician.

Charge Nurse
Emergency Psychiatric Services (EPS)
(408) 885-6100
FAX (408) 885-6117

B. Authorization

For uninsured patients in need of inpatient psychiatric services, you will need an **authorization** from the designated Hospital Liaison.

Santa Clara County Family & Children's Division
Hospital Liaison
Phone: (408) 794-0760
Phone: (408) 483-8030 (after hours, holidays)
FAX: (408) 938-4529

Santa Clara County Adult Older Adult Division
Hospital Liaison
Phone: (408) 885-3679

FAX: (408) 885-5789

Once you have obtained authorization, you must complete Notification of Hospitalization. The Authorization is not a preauthorization or guarantee of payment. Payment is made if the patient record submitted meets medical necessity criteria on a retrospective review.

C. Point of Authorization for Notification of Hospitalization & Treatment Authorization Requests

BHSD will conduct retrospective review of treatment authorizations following the first day of admission. The Psychiatric Facility must submit a Notification of Hospitalization Form no later than twenty-four (24) hours of patient admission. **(Appendix 7).** This form is used to notify BHSD of admission of Medi-Cal, unsponsored and Cal Medi-Connect patients to an inpatient psychiatric facility. For patients with secondary insurance, the provider is also responsible to notify the other insurance plan. For Cal Medi-Connect patients you must notify the Cal Medi-Connect Managed Care Plan listed in this manual.

Notification Hotline
Inpatient Utilization Review Coordinator
Phone: (408) 885-4867
Fax: (408) 279-0806
828 S. Bascom Avenue, Suite 200
San Jose, CA 95128
BHRetrospectiveReview@hhs.sccgov.org

The Notification Hotline phone and Fax lines are available twenty-four (24) hours a day, seven days a week. If you have additional questions, the URC will contact your facility on the next scheduled business day.

D. Cal Medi-Connect Managed Care Plans Contact Information

Anthem Blue Cross
Member Services
(855) 817-5785

Santa Clara Family Health Care Plan
210 E Hacienda Ave.
Campbell, CA 95008
877-723-4795
www.scfhp.com

E. Single Point of Contact (SPOC) Notification

BHSD requires that acute psychiatric inpatient providers/hospitals designate a Single Point of Contact (SPOC) for their facility. Initial and change notifications regarding facility designated SPOC must be sent to URC in writing, on the provider's letterhead, with the full name, mailing address, email address, telephone number and fax number of the new SPOC.

F. Single Point of Contact (SPOC)

A single point of contact is the person authorized to discuss or obtain information concerning a specific Treatment Authorization Request (TAR) or details about a patient.

The Inpatient Utilization Review Coordinator serves as the Single Point of Contact for BHSD.

Inpatient Utilization Review Coordinator (URC)
Phone: (408) 885-4867
Fax: (408) 279-0806
828 S. Bascom Avenue, Suite 200
San Jose, CA 95128
BHRetrospectiveReview@hhs.sccgov.org

All official correspondence addressed to BHSD must be submitted by the provider's designated SPOC and will be acted upon only if submitted in writing for matters such as, but not limited to, the following:

- TAR Inquiry
- Corrections and Resubmissions
- Compliance Unit
- First Level Appeal

G. Provider Alerts

The Plan will issue BHSD Provider Alerts to contract providers via the SPOC to disseminate information regarding clinical, administrative, or financial policies and procedures. Any changes described in the Provider Alerts have the authority of policy and are binding to the provider's contract agreement with BHSD.

5. REPORTING REQUIREMENTS

A. Contract Required Notifications

Contracted providers must notify the Hospital Liaison immediately of the following:

- Any/all changes affecting the provider's ability to provide contracted services
- Changes in ownership
- Mergers

- Financial viability
- Insurance
- Permits
- Licenses
- Staffing Pattern
- Other dated material and changes that are required from the contract package

Failure to formally inform, in writing, the Hospital Liaison, in a timely manner, of any/all conditions affecting the contract provider's ability to provide services may constitute a material breach of contract. Contract providers must submit all official correspondence and notices to the following:

Santa Clara County Family & Children's Division
Hospital Liaison
Phone: (408) 794-0760
Phone: (408) 483-8030 (after hours, holidays)
FAX: (408) 938-4529

Santa Clara County Adult Older Adult Division
Hospital Liaison
Phone: (408) 885-3679
FAX: (408) 885-5789

B. DHCS Quarterly Reports and BHSD Oversight

All psychiatric inpatient providers shall maintain Lanterman-Petris-Short (LPS) Facility Designation, submit the required quarterly reports to BHSD and have clinical staff that hold a current 5150 Card to conduct involuntary treatment assessment and evaluation activities. Refer to BHSD Policy #415-406 LPS Facility Designation, Redesignation and Reporting Requirements. Refer to **Appendix 5.**

C. Sentinel Events and AWOLS

BHSD Quality Management (QM) oversees the review, evaluation, and investigation of reported incidents in order to address issues involving quality of care and to identify system-wide patterns as part of a comprehensive quality improvement effort. QM is responsible for maintaining all records related to quality of care reporting and will determine if certain incidents, such as sentinel events, require a Critical Incident Review (CIR). To preserve the confidential review system, these reports and activities are maintained as confidential and are not disclosed outside the quality improvement process nor are these reports and proceedings subject to discovery pursuant to Welfare & Institutions Code§ 5328 and Evidence Code § 1157.6.

Whenever a Sentinel Event or AWOL related to a Santa Clara County Beneficiary occurs, Providers are required to document and report all critical Incidents to BHSD Plan Administration in a timely manner using the attached Behavioral Health Services Department (BHSD) Behavioral Health Services Department Incident Report Form. The form shall be completed for any event that causes or has the potential to cause physical or psychological injury and/or has the capacity for a claim or litigation resulting from an injury or risk of injury to a Beneficiary, Workforce Member, or visitor. **(Appendix 5D).** Refer to BHSD Policy #415-807 Quality of Care Reporting, Review, and Investigation.

D. Grievances, Appeals, NOABD

Any areas of concern regarding services to our beneficiaries noted by our care managers, MHAP, the Beneficiary, or their Representative will be communicated to the BHSD Medical Director and the LPS Facility Designation Team. The Medical Director (or their designee) will then communicate appropriate concerns directly to the physician in charge of the case, or to the facility Medical Director. Areas of concern may address Quality of Care issues which relate to clinical care or may address medical necessity issues which could impact continued need for an acute psychiatric hospital level of care.

If BHSD seeks to reduce deny or limit a service, we will issue a NOABD to the Beneficiary, their Representative, if applicable and the facility. The facility may act on behalf of the Beneficiary to request a review and reconsideration of an Adverse Benefit Determination. Refer to PP#415-820 for NOABD specific requirements and timelines.

6. GENERAL GUIDELINES

A. Eligibility

Providers must use the state operated Point of Service (POS) verification system monthly to check a patient's current Medi-Cal eligibility to meet the State standards. Patients that are Santa Clara County residents who have current or retroactive benefits or who are unsponsored (with authorization from Hospital Liaison) and meet Title 9 medical necessity criteria and require acute psychiatric inpatient services.

Facilities are responsible for verifying the patient's Medi-Cal, Cal Medi-Connect or other eligibility. The verification of eligibility must be printed out and be attached to the TAR. If the patient has Cal Medi-Connect, facility must notify both BHSD and the Cal Medi-Connect Managed Care Plan. If the patient is unsponsored, the facility must demonstrate the patient has no eligibility and obtain authorization from the appropriate hospital liaison

Contracted Inpatient providers are required to follow all federal, State, and County regulations and policies for all Medi-Cal beneficiaries.

Admissions should be based solely on the clinical review of the beneficiaries needs. If the beneficiary meets Title 9 Medi-Cal medical necessity criteria, inpatient services should not be delayed because of an authorization of payment decision. However, inpatient providers are required to notify the BHSD SPOC of all admissions.

B. Payment Authorization for Emergency Services

MHPs may not require prior authorization for an emergency admission for psychiatric inpatient hospital services or to a psychiatric health facility, whether the admission is voluntary or involuntary, and the beneficiary, due to a mental disorder, is a current danger to self or others, or immediately unable to provide for, or utilize, food, shelter, or clothing. Upon notification by a hospital, MHPs shall authorize payment for out-of-network services when a beneficiary of the MHP, with an emergency psychiatric condition, is admitted to a hospital, or PHF, to receive psychiatric inpatient hospital services or PHF services. After the date of admission, hospitals must request authorization for continued stay services for the beneficiary subject to retrospective review by the MHP in accordance with MHSUDS Information Notice 19-026.

Emergency services delivered to beneficiaries by any provider do not require prior authorization. These are reimbursable, subject to Utilization Review Coordination (URC) retrospective certification of medical necessity for such services. Emergency services are defined as follows:

> The presence, in a beneficiary, of a State-defined covered mental illness, and criteria which establish dangerousness to self or others, or a grave disability, which prevents the provision of care at a lower level of service.

Title 9 CCR § 1820.225. MHP Payment Authorization for Emergency Admissions by a Point of Authorization.

(a) The MHP shall not require a hospital to obtain prior MHP payment authorization for an emergency admission, whether voluntary or involuntary.
(b) The hospital providing emergency psychiatric inpatient hospital services shall assure that the beneficiary meets the criteria for medical necessity in §1820.205, and due to a mental disorder, is:
    (1) A current danger to self or others, or
    (2) Immediately unable to provide for, or utilize, food, shelter, or clothing.
(c) <u>The hospital providing emergency psychiatric inpatient hospital services shall notify the MHP of the county of the beneficiary within ten calendar days of the time of presentation for emergency services,</u> **<u>or within the timelines specified in the contract if a time requirement is included as a term of the contract between the hospital and MHP.</u>**

C. Utilization Review Coordination

The UM program must evaluate medical necessity, appropriateness, and efficiency of services provided to Medi-Cal beneficiaries through concurrent, prior, or retrospective authorization procedures. The UM program must include mechanisms to detect both underutilization and overutilization. The MHP must also maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse, including maintenance of a comprehensive compliance program.

BHSD conducts retrospective review and authorization for all psychiatric inpatient hospital services and psychiatric health facility services. For Medi-Cal reimbursement of psychiatric inpatient hospital services, the beneficiary must meet medical necessity criteria set forth in 9CCR, § 1820.205. The beneficiary must meet the following medical necessity criteria for admission to a hospital for psychiatric inpatient hospital services:

• Have an included diagnosis.

• Cannot be safely treated at a lower level of care, except that a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services for an acute psychiatric episode shall be considered to have met this criterion; and,

• Requires psychiatric inpatient hospital services, as the result of a mental disorder, due to one of the following:

1. Has symptoms or behaviors due to a mental disorder that (one of the following):
    - Represent a current danger to self or others, or significant property destruction.
    - Prevent the beneficiary from providing for, or utilizing, food, clothing, or shelter.
    - Present a severe risk to the beneficiary's physical health.
    - Represent a recent, significant deterioration in ability to function.
2. Require admission for one of the following:
    - Further psychiatric evaluation.
    - Medication treatment.
    - Other treatment that can be reasonably provided only if the beneficiary is hospitalized. The medical necessity criteria are applicable regardless of the legal status (voluntary or involuntary) of the beneficiary.

All payment requests for inpatient psychiatric hospital care which meet medical necessity and satisfy the parameters established within this Manual will be reimbursed.

Authorization of payment for psychiatric hospital stays will be made based on a retrospective review of the medical record of each patient for whom payment is requested. The medical record must conclusively document, on a daily basis, the continued requirement for an acute hospital level of care. Failure of daily documentation to establish the requirement for this level of care will result in denial of payment for all days in question.

No payment will be denied without the authorization of the BHSD Medical Director or his/her designee.

MHPs maintain responsibility to ensure that services furnished to beneficiaries are medically necessary and must ensure compliance with all requirements necessary for Medi-Cal reimbursement. As such, the MHP must review documentation sufficient to determine that medical necessity criteria are met for acute days and administrative day criteria are met for administrative days claimed for reimbursement of Federal Financial Participation. Decisions to approve, modify, or deny provider requests for authorization retrospective with the provision of SMHS to beneficiaries shall be communicated to the beneficiary's' treating providers, including both the hospital, and treating physician, in writing, within 24 hours of the decision.

If the MHP denies or modifies the request for authorization, the MHP must notify the beneficiary, in writing, of the adverse benefit determination. In the case of retrospective review, care shall not be discontinued until the beneficiary's treating provider(s) has been notified of the MHP's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the beneficiary. services, the MHP must notify the beneficiary, in writing, of the adverse benefit determination. In cases where the MHP determines it will terminate, modify, or reduce determination prior to discontinuing services.

D. Supporting Documentation Requirements

Provider will submit Treatment Authorization Request (TAR), proof of Medi-Cal or other eligibility and the patient record to:

Inpatient Utilization Review Coordinator
828 S. Bascom Avenue, Suite 200
San Jose, CA 95128
Phone: (408) 885-4867
Fax: (408) 279-0806

Patient record must be complete with the patient's name, medical record number, date and times of services provided on each page. A complete medical record will include:

- Face sheet
- 5150
- Conservatorship documents
- Discharge summary and discharge documentation forms
- Psychiatric Evaluation
- History and physical
- Physician orders
- Lab results
- **Treatment Plan signed by a physician for inpatient hospitalizations greater than 72 hours***

- MD progress notes
- Nursing notes
- Social service notes
- All 24 hour documentation
- Court hearing documentation
- Special observation/restraint documentation
- Medication administration Record
- Medication consents
- Discharge summary that contains an included diagnosis

BHSD will review for medical necessity criteria. If the documentation supports the need for acute psychiatric care, BHSD will submit the TAR to the state Fiscal Intermediary and the Inpatient Psychiatric Facility will, in most cases, will need to bill the state Fiscal Intermediary.

A day of service is to be billed for each patient who meets admission criteria and/or continued stay criteria, documentation requirements, treatment and discharge planning requirements and occupies a psychiatric inpatient hospital bed in the facility prior to midnight, excluding the day of discharge. Occupies is defined as the patient has arrived and is being observed and monitored in the inpatient psychiatric facility prior to midnight on the day of service.

The County accepts no responsibility for services provided to members where there is a responsible third party payer. The provider must bill the third party payer. Should the County inadvertently make payment for such a patient, the provider will reimburse the County for this payment.

For fee for service organizations, the provider will bill its usual and customary charges to the state fiscal intermediary.

Medi-Cal Fiscal Intermediary
Conduent
820 Stillwater Road
West Sacramento, CA 95605-1630
1-800-786-4346

7. REIMBURSEMENT OF ACUTE PSYCHIATRIC INPATIENT SERVICES

A. Process

A description of the process for requesting reimbursement authorization for admission to acute inpatient services is as follows:

- Authorizations for services are provided retrospectively and are based on the documentation in the patient's medical record submitted by the provider.
- In order for the URC to authorize reimbursement, documentation must conclusively demonstrate the patient:

- Meets criteria for admission
    - Have a qualifying diagnosis
    - Meets medical necessity criteria
    - Has a valid treatment plan that is signed by an MD for inpatient stays greater than 72 hours.
    - Has a definitive discharge summary with qualifying diagnoses.
- For cases in which the provider indicates, or the MHP determines, that following the standard procedure could jeopardize the life of the patient or their health, ability to attain, maintain, or regain maximum function, BHSD UR Medical director or designee will make an expedited authorization decision as expeditiously as the patient's health condition requires. In the case of an expedited authorization request, requests will be determined in accordance with regulations, no more than three (3) days.

Per Santa Clara County Behavioral Health Services Department Policy #415-805 Beneficiary Problem Resolution Process:

Expedited Requests. An expedited request occurs when the standard process could jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum functioning. If the beneficiary's expedited hearing request is approved, a decision will be issued within three (3) working days of the date of the request. Expedited requests may include grievances, appeals and state fair hearings. Expedited requests must be resolved within 72 hours of receipt of the request.

Title 9, CCR § 1820.220. MHP Payment Authorization by a Point of Authorization.

(i) A Point of Authorization shall approve or deny the request for MHP payment authorization within 14 calendar days of the receipt of the request and, for a request from a Fee-for-Service Medi-Cal hospital, shall submit the TAR to the fiscal intermediary within 14 calendar days of approval or denial. The MHP shall consider a possible extension in accordance with timelines of title 42 CFR § 438.210(d)(1). If the MHP extends the timeframe, the MHP shall provide the beneficiary with written notice of the decision on the date the decision to extend is made. The notice to the beneficiary shall advise the beneficiary of the reason for the decision and the beneficiary's right to file a grievance if the beneficiary disagrees with the decision. **The Point of Authorization shall provide for an expedited review of an MHP payment authorization request in accordance with title 42, Code of Federal Regulations, § 438.210(d)(2), when the MHP determines or the hospital certifies that following the 14 calendar day time frame would seriously jeopardize the beneficiary's life, health, or ability to attain, maintain or regain maximum function.**

B. Medi-Cal Medical Necessity Criteria

BHSD Inpatient QA uses the following criteria to determine TAR eligibility:

Title 9, CCR § 1820.205. Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient Hospital Services.

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

1. One of the following diagnoses in the Diagnostic and Statistical Manual of Mental Disorders, current edition published by the American Psychiatric Association:
    - A. Pervasive Developmental Disorders
    - B. Disruptive Behavior and Attention Deficit Disorders
    - C. Feeding and Eating Disorders of Infancy or Early Childhood
    - D. Tic Disorders
    - E. Elimination Disorders
    - F. Other Disorders of Infancy, Childhood, or Adolescence
    - G. Cognitive Disorders (only Dementias with Delusions, or Depressed Mood)
    - H. Substance Induced Disorders, only with Psychotic, Mood, or Anxiety Disorder
    - I. Schizophrenia and Other Psychotic Disorders
    - J. Mood Disorders
    - K. Anxiety Disorders
    - L. Somatoform Disorders
    - M. Dissociative Disorders
    - N. Eating Disorders
    - O. Intermittent Explosive Disorder
    - P. Pyromania
    - Q. Adjustment Disorders
    - R. Personality Disorders
2. Both the following criteria:
    - A. Cannot be safely treated at a lower level of care, except that a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services for an acute psychiatric episode shall be considered to have met this criterion; and
    - B. Requires psychiatric inpatient hospital services, as the result of a mental disorder, due to the indications in either Subsection (a) (2) (B) 1. or 2. below:
        1. Has symptoms or behaviors due to a mental disorder that (one of the following):
            - a. Represent a current danger to self or others, or significant property destruction.
            - b. Prevent the beneficiary from providing for, or utilizing, food, clothing, or shelter.
            - c. Present a severe risk to the beneficiary's physical health.

d. Represent a recent, significant deterioration in ability to function.

2. Require admission for one of the following:
   a. Further psychiatric evaluation.
   b. Medication treatment.
   c. Other treatment that can reasonably be provided only if the patient is hospitalized.

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

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

C. Non-Qualifying Diagnoses

a. Mental Retardation
b. Learning Disorders
c. Motor Skills Disorders
d. Communication Disorders
e. Delirium
f. Dementia (except Vascular Dementia with Delusions or Depressed Mood)
g. Amnestic Disorders
h. Cognitive Disorder NOS
i. Mental Disorders Due to a General Medical Condition
j. Substance-Induced Disorders (except Substance Induced Psychotic, Mood or Anxiety Disorders)
k. Factitious Disorders
l. Sexual and Gender Identify Disorders
m. Sleep disorders
n. Impulse control Disorders Not Elsewhere Classified (except Intermittent Explosive Disorder and Pyromania)
o. Other Conditions That May Be a Focus of Clinical Attention (V codes)

8. REIMBURSEMENT OF CONTINUED STAY IN ACUTE INPATIENT SERVICES

A. Criteria for a Patient's Continued Stay

Continued stay services in a hospital shall be reimbursed when a beneficiary experiences one of the following:

- Continued presence of indications that meet the medical necessity criteria.
- Serious adverse reaction to medications, procedures or therapies requiring continued hospitalization.

- Presence of new indications that meet medical necessity criteria.
- And the need for continued medical evaluation or treatment that can only be provided if the beneficiary remains in the hospital.

In order for URC to authorize reimbursement for continued stay in acute inpatient services, the patient must continue to meet **Title 9 CCR § 1820.205. Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient Hospital Services** noted for admission to inpatient services described in the Medi-Cal Medical Necessity Criteria Section of this manual. Continued stay in an acute psychiatric inpatient hospital will only be reimbursed when a patient experiences one of the following:

- Continued stay services in a hospital shall be reimbursed when a beneficiary experiences one of the following:
    - Continued presence of indications that meet the medical necessity criteria.
    - Serious adverse reaction to medications, procedures or therapies requiring continued hospitalization.
- Presence of new indications that meet medical necessity criteria; and,
- Need for continued medical evaluation or treatment that can only be provided if the beneficiary remains in the hospital.

9. REIMBURSEMENT OF ADMINISTRATIVE DAYS

Administrative days are defined in Title 9 as psychiatric inpatient hospital care provided when the patient's stay at the hospital must be continued beyond needed acute treatment days due to a temporary lack of placement options at appropriate, non-acute treatment Inpatient Psychiatric Facilities.

A. Process for Administrative Days

- The expectation is that inpatient psychiatric hospitals make 5 contacts per week on behalf of patients in order to be eligible for administrative days. (1 contact per week and exemptions) Documentation must include:
    - Date of the contact.
    - Name of the person and facility contacted.
    - Facility response regarding availability of beds (status).
    - Signature of the person making the contact.
    - For IMD placement status prior to 24 Hour Care placement approval, date of the contact (on a weekly basis), name of 24 Hour Care staff contacted, number of clients on the waiting list status and the signature of the person making the contact must be included in the documentation.
- The requesting inpatient psychiatric facility will submit the entire patient record and a separate TAR requesting administrative days.
- The URC conducts a retrospective review, to determine if the patient on a waiting list for placement at an approved county licensed facility. Note for Cal Medi-Connect patients, the facility must ensure that placement is with an approved Cal Medi-Connect contracted facility.

- If the facility is not referring the patient to a county approved licensed facility the facility will not qualify for administrative days. Refer to **Appendix 5** for information about county contracted providers.

Approved Placement Types

a) State Hospital
b) Institutes for Mental Disease (IMD)
c) Crisis Residential
d) Augmented Board and Care
e) Skilled Nursing Facility
f) STRTP

B. Criteria for Administrative Days

Requests for BHSD payment authorization for administrative day services shall be approved by the URC when both of the following conditions are met:

1. During the hospital stay, the patient previously had met medical necessity criteria for acute psychiatric inpatient hospital services. There must be at least one approved acute day prior to claims for an administrative day.
2. There is no appropriate, non-acute residential treatment facility within a reasonable geographic area and the hospital documents contacts with a minimum of five appropriate, non-acute residential treatment Inpatient Psychiatric Facilities per week for placement of the patient subject to the following requirements.
    a. BHSD can waive the requirements of five contacts per week if there are fewer than five appropriate, non-acute residential treatment Inpatient Psychiatric Facilities available as placement options for the patient. In no case shall there be less than one contact per week.
    b. The lack of placement options at appropriate residential treatment Inpatient Psychiatric Facilities and the contacts made at appropriate treatment Inpatient Psychiatric Facilities shall be documented include but not be limited to:
        i. The status of the placement option.
        ii. Date of the contact.
        iii. Signature of the person making the contact
        iv. Decision of inquiry (yes or no)
3. For the hospital's documentation of the facility's response to bed availability, statements such as "pending", "received fax", "reviewing packets", "contacting Public Guardian" are not acceptable. There must be a follow-up documentation of the outcome of the facility's review of the packet within the identified week or 7- day period. The "week" starts on the date that administrative days was ordered.

C. Authorizing Administrative Days

A hospital may claim for administrative day services when a beneficiary no longer meets medical necessity criteria for acute psychiatric hospital services but has not yet been accepted for placement at a non-acute residential treatment facility in a

reasonable geographic area. In order to conduct retrospective review and authorization for administrative day service claims, the MHP shall review that the hospital has documented having made at least one contact to a non-acute residential treatment facility per day (except weekends and holidays), starting with the day the beneficiary is placed on administrative day status. Once five contacts have been made and documented, any remaining days within the seven-consecutive-day period from the day the beneficiary is placed on administrative day status can be authorized. A hospital may make more than one contact on any given day within the seven-consecutive-day period; however, the hospital will not receive authorization for the days in which a contact has not been made until and unless all five required contacts are completed and documented. Once the five-contact requirement is met, any remaining days within the seven-day period can be authorized without a contact having been made and documented.

MHSUDS Information Notice 19-026. Authorization of Specialty Mental Health Services

> A hospital may claim for administrative day services when a beneficiary no longer meets medical necessity criteria for acute psychiatric hospital services but has not yet been accepted for placement at a non-acute residential treatment facility in a reasonable geographic area. The MHP shall review that the hospital has documented having made at least one contact to a non-acute residential treatment facility per day (except weekends and holidays), starting with the day the beneficiary is placed on administrative day status. Once five contacts have been made and documented, any remaining days within the seven-consecutive-day period from the day the beneficiary is placed on administrative day status can be authorized. A hospital may make more than one contact on any given day within the seven-consecutive-day period; however, the hospital will not receive authorization for the days in which a contact has not been made until and unless all five required contacts are completed and documented. Once the five-contact requirement is met, any remaining days within the seven-day period can be authorized without a contact having been made and documented.
>
> MHPs may waive the requirements of five contacts per week if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options for the beneficiary. The lack of appropriate, non-acute treatment facilities and the contacts made at appropriate facilities shall be documented to include the status of the placement, date of the contact, and the signature of the person making the contact.
>
> Examples of appropriate placement status options include, but may not be limited to, the following:
>
> - The beneficiary's information packet is under review.
> - An interview with the beneficiary has been scheduled for [date].
> - No bed available at the non-acute treatment facility.

- The beneficiary has been put on a wait list.
- The beneficiary has been accepted and will be discharged to a facility on [date of discharge].
- The patient has been rejected from a facility due to [reason].
- And/or a conservator deems the facility to be inappropriate for placement.

D. Other issues regarding Administrative Days are:

- Administrative Days end when the patient is discharged from the inpatient setting, when the patient enters the chosen facility, or when the patient no longer meets criteria for admission to the facility based on level of care guidelines and medical necessity criteria. Administrative Days will also end if the discharge plan changes to a type of facility that is not one mentioned above.

- If a patient's condition improves while they are waiting for placement at a facility, administrative days will be authorized up to the day the patient no longer meets medical necessity criteria for admission to an approved type of facility as noted above.

10. RETROSPECTIVE AUTHORIZATION REVIEW

After BHSD receives guidance from DHCS around the retrospective review process, BHSD will only accept **Retrospective Review** requests under the following limited circumstances:

- Retroactive Medi-Cal eligibility determinations.
- Inaccuracies in the Medi-Cal Eligibility Data System.
- Authorization of services for beneficiaries with other health care coverage pending evidence of billing, including dual-eligible Beneficiaries.
- Beneficiary's failure to identify payer (e.g., for inpatient psychiatric
- hospital services).
  - In cases where the review is retrospective, the MHP's authorization decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination and shall be communicated to the provider in a manner that is consistent with state requirements.

Treatment Authorization Requests (TARs) submitted late (Retro TARs) without a reasonable explanation may be denied.

11. ELECTROCONVULSIVE THERAPY (ECT)

A. Inpatient ECT

Inpatient ECT does not require a separate authorization if the patient continues to meet Title 9 criteria. The ECT consult is Medi-Cal reimbursable and BHSD URC authorizes payment to a network provider. However, reimbursement is for the inpatient per diem rate. ECT is not separately reimbursed. (part of rate they get paid.)

B. Excessive Use ECT Authorization

Facilities must obtain BHSD approval for convulsive treatment in both inpatient and outpatient settings if more than 15 treatments are to be given to a patient in a 30 day period or more than 30 treatments are to be given to a patient within a one year period. The referring psychiatrist is responsible for providing documentation for the need for ECT **(Appendix 10)** and submit the materials to the appropriate BHSD Hospital Liaison. The Hospital Liaison will coordinate with the specific managed care plan medical director to obtain a decision and if approved, to coordinate treatment with the provider.

Santa Clara County Family & Children's Division
Hospital Liaison
Phone: (408) 794-0760
Phone: (408) 483-8030 (after hours, holidays)
FAX: (408) 938-4529

Santa Clara County Adult Older Adult Division
Hospital Liaison
Phone: (408) 885-3679
FAX: (408) 885-5789

Title 9, CCR § 849. Excessive Use of Convulsive Treatment.

a) Convulsive treatments shall be considered excessive if more than 15 treatments are given to a patient within a 30-day period, or a total or more than 30 treatments are given to a patient within a one-year period.
b) If, in the judgment of the attending physician, more than the above limits are indicated, prior approval must first be obtained from the review committee of the facility or county, whichever is appropriate. (§§847 and 848.) Requests for approval shall include documentation of the diagnosis, the clinical findings leading to the recommendation for the additional treatments, the consideration of other reasonable treatment modalities and the opinion that additional treatments pose less risk than other potentially effective alternatives available for the particular patient at the present time. A maximum number of additional treatments shall be specified. The review committee shall act upon any such request within seven days of its receipt and shall document the maximum number of additional treatments approved. All applicable informed consent procedures shall also be followed.

C. Outpatient ECT Authorization Process

All outpatient convulsive treatment requires a Prior Authorization. The referring psychiatrist must provide documentation of the need for ECT **(Appendix 10)** and submit the materials to the appropriate BHSD Hospital Liaison. The Hospital Liaison will coordinate with the specific patient managed care plan medical director to obtain a decision and if approved, to coordinate treatment with the provider.

Link to OP ECT Auth Form

Description 2 authorizations Health Plan responsible for payment of anesthesiologist and room change – SMHS does not reimburse.

GZB2ZZZ	Electroconvulsive Therapy, Bilateral-Single Seizure
GZB3ZZZ	Electroconvulsive Therapy, Bilateral-Multiple Seizure

- Covered Behavioral Health CPT Codes are:

90870	Electroconvulsive Therapy (ECT), includes necessary monitoring

HB contract codes evaluation and OP – El Camino, Altos, Stanford, Sutter SAC

12. ADULT TRANSFERS TO ACUTE INPATIENT PSYCHIATRIC HOSPITALS

Santa Clara County operates both Emergency Psychiatric Services (EPS) and Barbara Aron's Pavilion. EPS is a locked psychiatric emergency room for the Adult and Older Adult (AOA) population, operated by the Acute Psychiatric Services Division of Valley Medical Center (VMC) and is the only LPS Designated locked psychiatric emergency room in Santa Clara County. EPS provides 72 hour evaluation, crisis stabilization and appropriate referral to involuntary and voluntary patients. EPS facilitates transfers to other LPS Inpatient Psychiatric Facilities based on patient census at Barbara Aron's Pavilion (BAP) and patient level of care needs. For additional AOA Acute Inpatient Psychiatric Hospitals for AOA, refer to **Appendix 6B** of this Handbook.

Children Youth and Family (CYF) Acute Inpatient Psychiatric Hospital placement information is referenced in **Appendix 6A.**

13. MEDICATION GUIDELINES

The standard of care in the community is to send all discharging patients with either a prescription or medications in hand. Indigent patients can have medications prescribed through BHSD Central Wellness and Benefits Center after receipt of an assessment. Prescriptions are filled at the Enborg Pharmacy.

BHSD has a Medication Practice Guidelines Manual to standardize the delivery of psychiatric treatment to patients with behavioral health issues in Santa Clara County. Follow this guide to ensure that formulary requirements are met to optimize the patient's care and ease of obtaining prescriptions.

https://bhdp.sccgov.org/medical-pharmacy-services/santa-clara-county-behavioral-health-department-medication-practice

A. Polypharmacy on Discharge

The following definition of Polypharmacy is based on: National guidelines, regulatory agencies such as: JCAHO and community/national prescribing practices:
Polypharmacy is herein defined as:

a. Two or more antipsychotics
b. Antidepressants: Two or more: SSRIs, SNRIs, SSRI + SNRI
c. Anti-anxiety/Hypnotic agents:
   i. ≥2 benzodiazepines
   ii. ≥2 non-benzodiazepines
   iii. A benzodiazepine plus a non-benzodiazepine i.e., zolpidem, zaleplon and eszopiclone
d. Two or more anticonvulsant mood stabilizers

When considering addition of more than one agent within a class, it is recommended to first titrate the initial agent to maximum tolerated dose; then provide clear supportive rationale for the additional agent(s).

When changing medications, a process of cross-tapering is recommended and may require up to 90 days to accomplish. If polypharmacy is necessary beyond the maximum period of 90 days to complete cross-tapering, clear documentation of the rationale for continuation of the polypharmacy is necessary.

Anti-dyskinetic, antihistamine, beta-blocking, thyroid medications, and Low dose. Trazodone (up to 200mg) used as a hypnotic is excluded from the calculation of polypharmacy.

Per Joint Commission, National Quality Measure HBIPS-5, the following constitute appropriate justifications for multiple antipsychotic medications:

a. Cross-titration
b. Minimum of 3 failed monotherapy
c. Augmentation to Clozapine
d. Other justification than above A-C
e. No justification/Unable to Determine

*On-going use of polypharmacy requires clear documentation of one of the above allowable justifications. Failed monotherapy must include specifics such as: dosage, duration of therapy and the clinical response. For patients admitted or transferred on a polypharmacy regimen (as defined above), justification for continuing the regimen beyond 90 days must be clearly documented, including a risk-benefit analysis of maintaining versus changing to monotherapy. A justification that the patient's

symptoms are stable on the regimen should be reserved for cases where the patient is either currently asymptomatic or experiencing only mild symptoms.

It is recognized that severely ill patients may require combinations of antipsychotic treatments (e.g., patients coming out of state hospitals and IMDs.) It is generally expected that the outpatient psychiatrists will re-evaluate the need to continue the discharge medications and consider adjustment of the regimen to reduce polypharmacy when the client has stabilized.

According to the Expert Consensus Guidelines on Optimizing Pharmacologic Treatment of psychotic disorders (2003): if a patient experiences symptom relapse despite compliance with treatment, it is recommended to switch to a different agent, maximize the dose of the current medications, or switch to long-acting injectable medications.

The lowest effective dose of any medication should generally be sought, especially in stable, chronic individuals or in the treatment of elderly, children, individuals with disabilities, and those with co-existing medical conditions.

If the prescribed medication is outside of the SCVHHS formulary (for UMDAP patients), the necessity for such a regimen must be documented and approval of the Non-Formulary Drug Request (NFDR) Form required from the Medical Director or her designee.

Polypharmacy (Documentation Required)

a. Documentation regarding failed monotherapy must include specifics such as: dosage, duration of therapy and the clinical response (see purpose section of medication guideline for patients that are currently on polypharmacy i.e., at the time of transfer).
b. Use of more than one antipsychotic agent beyond the 90 days cross titration period requires the following documentation:
    i. That a risk/benefit analysis was performed and discussed with the patient
    ii. The rationale for not attempting to taper or discontinue the polypharmacy regimen every 6-month period

B. Long Acting Injectables

Applicable to Abilify Maintena® (Aripiprazole) extended-release injectable suspension, for IM use ONLY:

- Prior to starting Abilify Maintena, Aripiprazole naïve patients require up to two weeks of oral Aripiprazole to establish tolerability. (Note: The elimination t1/2 of oral aripiprazole is about 75 hours. Since medications take about 4-5 half-lives to reach steady state, oral aripiprazole will reach steady state in approximately 12.5 to 15.5 days.)
- After the first Abilify Maintena injection, continue with oral aripiprazole or other antipsychotics for two weeks to maintain therapeutic antipsychotic concentration during initiation of therapy.

- If patients experience adverse reactions with the 400 mg, consider decreasing the dosage to 300 mg once monthly.
- Dosage adjustment needed for 2D6 poor metabolizer and/or with 3A4 inhibitors (see PI for details).

Applicable to Aristada® (Aripiprazole Lauroxil) extended-release injectable suspension, for IM use ONLY:

- For patients naïve to aripiprazole, establish tolerability with oral aripiprazole prior to initiating treatment with Aristada.
- Two options with initiating Aristada:
    - Aristada Initio: Give one 30 mg dose of PO aripiprazole and one 675 mg Aristada Initio injection with the first Aristada injection OR
    - PO Aripiprazole: Give 21 consecutive days of PO aripiprazole with the first Aristada injection

Total Daily Dose of PO Aripiprazole to Aristada	
PO Aripiprazole	IM Aristada
10 mg/day	441 mg q month
15 mg/day	662 mg q month 882 mg q6 weeks 1064 mg q2 months
≥20 mg/day	882 mg q month

- Dosage adjustments are required for:
    a. Known CYP2D6 poor metabolizers and
    b. For patients taking CYP3A4 inhibitors, CYP2D6 inhibitors, or CYP3A4 inducers for more than 2 weeks (See prescriber information (PI) for more details).

- For patients with both strong CYP3A4 and strong CYP2D6, avoid 662 mg, 882 mg, or 1064 mg doses of Aristada
- DO NOT substitute Aristada Initio for Aristada

Applicable to Invega Sustenna® (Paliperidone Palmitate) extended-release injectable suspension, for IM use ONLY:

- For patients who have never taken oral paliperidone or oral or injectable risperidone, it is recommended to establish tolerability with oral paliperidone or oral risperidone prior to initiating treatment with Invega Sustenna®.
- Upon initiation of therapy with Invega Sustenna®, cross coverage with oral paliperidone or risperidone is not necessary.
- Invega Sustenna is not recommended for patients with moderate-to-severe renal impairment (CrCl < 50 mL/min).
- For patients with mild renal impairment (CrCl ≥ 50 mL/min to < 80 mL/min), administer 156 mg on day 1 of treatment and 117 mg one week later (both

administered in the deltoid muscle). Continue with monthly 78 mg injections in either the gluteal or deltoid muscle.

Applicable to Invega Trinza® (3-month Paliperidone Palmitate) extended-release injectable suspension, for IM use ONLY:

- Invega Trinza should be used only after the patient has been adequately treated with the 1-month Invega Sustenna IM for at least four months.
- Invega Trinza should be administered once every 3 months.

Last Dose of Invega Sustenna	Following Invega Trinza Dose
78 mg	273 mg
117 mg	410 mg
156 mg	546 mg
234 mg	819 mg

- Invega Trinza is not recommended for patients with moderate-to-severe renal impairment (CrCl < 50 mL/min).
- For patients with mild renal impairment (CrCl ≥ 50 mL/min to < 80 mL/min), adjust dosage and stabilize the patient on Invega Sustenna then transition to Invega Trinza using the above conversion.

Applicable to Risperdal Consta® (Risperidone) LAI, for IM use ONLY:

- For patients who have never taken oral risperidone, it is recommended to establish tolerability with oral risperidone prior to initiating treatment with Risperdal Consta.
- Oral risperidone (or another antipsychotic medication) should be given with the first injection of Risperidal Consta and continued for 3 weeks (and then discontinued) to ensure that adequate therapeutic plasma concentrations are maintained prior to the main release phase of risperidone from the injection site.
- Dose increases of Risperdal Consta should not be made more often than 4 weeks. Clinical effects of each increased dose titration adjustment should not be anticipated sooner than 3 weeks after each injection.

Applicable to Perseris® (Risperidone) for extended-release injectable suspension, for subcutaneous (SQ) use ONLY:

- No loading dose or oral supplementation recommended.
- Prior to starting Perseris, establish tolerability with oral risperidone in risperidone-naïve patients.
- Patients who are on stable oral risperidone doses lower than 3 mg/day or higher than 4 mg/day may not be candidates for Perseris.
- Perseris is administered monthly by abdominal subcutaneous injection ONLY.
- Perseris is available in 90 mg and 120 mg syringes and need to be refrigerated and brought to room temperature for 15 minutes prior to mixing. (Note: When mixing the powder and liquid syringe, "1 cycle" of mixing occurs after transferring the contents of the liquid syringe into the powder syringe

AND BACK from the powder syringe into the liquid syringe. Pre-mixing requires 5 gentle cycles, while thorough mixing requires an additional 55 cycles; the mixing can be more vigorous within the 55 cycles than when pre-mixing.)

Perseris 90 mg is expected to produce a plasma level similar to that of 3 mg/day of oral risperidone and Perseris 120 mg equates to 4 mg/day of oral risperidone.

14. PAYMENT AUTHORIZATION

A. Payment Authorization by Facility Type

BHSD, in accordance with Title 9, CCR § 1820.215. MHP Payment Authorization -General Provisions, the URC will retrospectively review payment authorization requests from:

1. Fee-for-Service/Medi-Cal Hospitals
2. Contracted Short/Doyle/Medi-Cal Hospitals
3. Non-contracted Short/Doyle/Medi-Cal Hospitals

Payment will be authorized only for patients that meet medical necessity criteria, for uninsured, have also received prior written approval from the appropriate Hospital Liaison.

Title 9, CCR § 1820.215. MHP Payment Authorization -General Provisions.

(a) The MHP payment authorization shall be determined for:

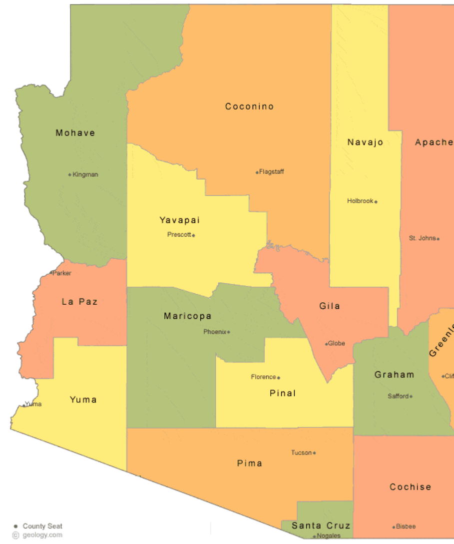
- (1) Fee-for-Service/Medi-Cal hospitals, by an MHP's Point of Authorization.
- (2) Short-Doyle/Medi-Cal hospitals contracting with the MHP, by either:
  - A. An MHP's Point of Authorization, or
  - B. The hospital's Utilization Review Committee, as agreed to in the contract for TAR Free pilot programs.
- (3) Short-Doyle/Medi-Cal hospitals that do not have a contract with the MHP, by an MHP's Point of Authorization.

The MHP that approves the MHP payment authorization shall have financial responsibility as described in this Chapter for the services authorized, unless financial responsibility is assigned to another entity pursuant to Title 9, CCR § 1850.405 and 1850.505 or unless the services are provided to patients eligible for the County Medical Services Program (CMSP). Services provided to patients eligible for the CMSP shall be authorized by the MHP for that county, but the MHP will not be responsible for payment of those services.

B. Out of State Inpatient Psychiatric Hospitals

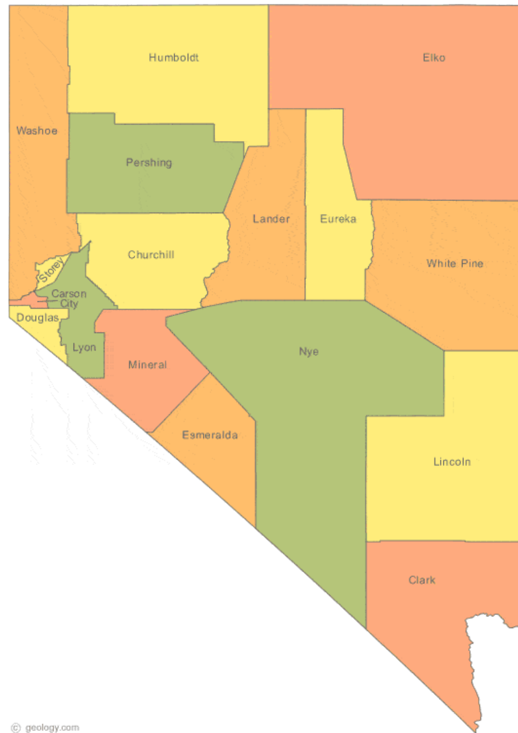
Medi-Cal, the state of California's Medicaid program may authorize payment of inpatient psychiatric services for counties that border the state. Refer to the maps on the next page for details.

Arizona



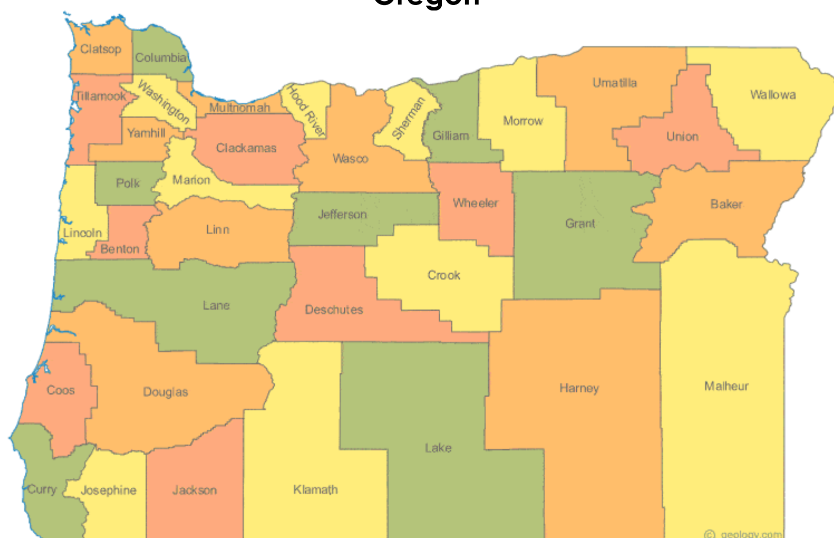
Mojave, La Paz and Yuma Counties

Nevada



Clark, Nye, Esmeralda, Douglas, Mineral, Lyon, Carson City, Washoe Counties

Oregon



Curry, Josephine, Jackson and Klamath and Lake Counties

For out of state inpatient psychiatric hospitalizations to states that do not border California, and those who do not have counties that border California, you must complete an **out of state Express Enrollment Form to enroll as an out-of-state Medi-Cal provider in order to obtain payment.** Refer to the link below.

http://files.medi-cal.ca.gov/pubsdoco/Publications/masters-other/provappsenroll/25enrollment_DHCSMC4603_oosenroll.pdf

After enrollment you will bill the state fiscal intermediary directly.

Medi-Cal Fiscal Intermediary
Conduent
820 Stillwater Road
West Sacramento, CA 95605-1630
1-800-786-4346

C. Treatment Authorization Request (TAR)

A TAR Manual is distributed by the State Department of Health Care Services (DHCS) formally Department of Mental Health (DMH). The most recent version is found here:

http://files.medi-cal.ca.gov/pubsdoco/outreach_education/workbooks/modules/bb/tar_bb.pdf

This manual is most helpful in delineating instructions regarding completing TARs. Please contact BHSD URC, Santa Clara County BHSD or State DHCS for a copy of this handbook if you do not have the most recent version.

BHSD required that both Fee-for-Service/Medi-Cal Hospitals and Short Doyle Medi-Cal Hospitals submit a TAR to request payment authorization from the BHSD URC.

D. Ordering TAR Form 18-3

TAR Form 18-3 is supplied by Medi-Cal. Use the DHCS Fiscal Intermediary (FI) Provider Forms Reorder Request card to order this form or go online:

http://files.medi-cal.ca.gov/pubsdoco/Publications/Misc/TAR_3_Attachment_Form.pdf

E. TAR Update Transmittal (TUT) Form 18-3

Providers needing to update an 18-3 mental health TAR may do so using the TAR Update Transmittal (TUT) Form 18-3. Providers can access the latest version of the TUT Form 18-3:

http://files.medi-cal.ca.gov/pubsdoco/Publications/masters-other/Misc/18-3_TUT_form.pdf

Providers submitting a TUT Form 18-3 need to reattach the original TAR they would like to update. Providers must send the TUT Form 18-3 and the original TAR to the address listed on the TUT Form 18-3.

F. Submitting Treatment Authorization Requests (TARs)

A *Treatment Authorization Request* form, *Request for Mental Health Stay in Hospital* (TAR Form 18-3), must be completed when requesting authorization for the following admissions:

- Continued stay services for recipients requiring additional services beyond the planned admission period
- Emergency admissions. Emergency admissions are exempt from prior authorization. However, the hospital must notify the MHP in the recipient's county of residence within 24 hours of admission. If notification is not received within 24 hours, the MHP may deny the hospital stay. (See *California Code of Regulations* [CCR], Title 9, § 1778.)

The provider shall submit an original Treatment Authorization Request (TAR) form and client record to BHSD URC. BHSD URC reviews the TAR and forwards it to the state's fiscal intermediary. The state fiscal intermediary will deny TARs sent directly to them by a contract hospital. All TARs for Santa Clara County Medi-Cal residents must be approved by BHSD URC prior to submission to the state fiscal intermediary, the contractor for Medi-Cal payment.

Incomplete TARs or TARs completed with erroneous or conflicting information will not be processed and will be returned to the hospital of origin to complete/resubmit.

*Please note that TARS require an original physician signature. TARs that are signed by a nurse for the physician or have a stamped signature will be denied by BHSD URC and the fiscal intermediary.

Timelines for Initial Submission of a TAR

Provider has **fourteen (14) calendar days** after discharge to submit a complete TAR & relevant documentation to BHSD

BHSD has **fourteen (14) calendar days** after receipt of TAR and documentation to make a decision.

BHSD has **fourteen (14) calendar days** after decision to send reviewed and completed TAR to the state Fiscal Intermediary and the Provider.

Timelines for a Retroactive TAR

Submit a retroactive TAR within **sixty (60) calendar days** of:

- Discovery of Medi-Cal eligibility or from a third party payer
- Notice of Partial Payment or
- Exhaustion of Benefits (EOB)

All TARs must include the facility's National Provider Identifier (NPI) Number. Fiscal intermediary will not accept TARs without the facility's NPI Number.

G. Processing TARS

Within fourteen (14) calendar days of receipt of the completed TAR from the provider, BHSD URC Utilization Management staff reconciles the information on the TAR with clinical information obtained during admission and retrospective review and submits the completed and approved TAR to Fiscal intermediary for payment processing via certified mail. A copy is forwarded to the provider.

If the BHSD URC has previously authorized days for the recipient's admission but considers continuation of stay not to be medically necessary, the BHSD will deny an extension of hospital stay.

The provider may appeal non-authorization by following the appeals procedure described in the Appeals section of this handbook.

H. TAR Timelines

The following timelines are Title 9 requirements for submission of TARs.
Provider must submit TAR to BHSD URC:

- Within fourteen (14) calendar days of patient discharge.

Provider must submit a separate TAR to BHSD URC:

- When ninety-nine (99) calendar days of continuous service are provided to a patient and if the hospital stay will exceed that period of time.

Note: TARs submitted for review after the timelines specified above must include an explanation of why the TAR is being submitted late. TARs submitted late (Retro TARs) without a reasonable explanation may be denied.

I. Retroactive TARs

The hospital is required to send copies of the entire patient chart and documentation as to why a TAR is being sent retroactively. Retroactive TARS are only accepted for the following reasons:

- A natural disaster
- Other circumstances beyond the hospital's control- this **does not** include negligence, misunderstanding of requirements, illness or absences, or delays by postal services.
- Eligibility was delayed by County Welfare Department
- Other coverage denied payment of a claim for service
- Communication with the field office consultant could not be established
- The beneficiary concealed Medi-Cal eligibility at the time of admission

All Retroactive TARS must be submitted within one year from the date of the patient's retroactive eligibility. TARS which are not submitted in a timely manner will be administratively denied.
Treatment Authorization Requests (TARs) submitted late (Retro TARs) without a reasonable explanation may be denied.

J. Claims Over One (1) Year Old

The state's Fiscal Intermediary reviews all original claims delayed over one year from the month of service due to:

1. Court decisions
2. Fair hearing decisions
3. County administrative errors in determining recipient's eligibility
4. Reversal of decisions on appealed TARS
5. Medicare/other health coverage delays
6. Circumstances beyond the provider's control

These claims must be submitted to the following special address:

Over-one-year Claims Unit
P.O. Box 13029
Sacramento, CA 95813-4029

Note: When appropriate, the BHSD URC will validate circumstances resulting in late claims.

K. Medi-Cal as Secondary Insurance

When the primary insurance is Medicare, notify the BHSD URC. If it is apparent that the patient's Medicare coverage will expire or be exhausted within five (5) days, then retrospective review and TARs submission will be conducted in the same manner as if Medi-Cal was primary. Please note that although reviews will occur within five (5) days of Medicare expiration, payment authorization must be based on information presented at the time Medicare coverage expires.

Should the hospital discover after discharge that a patient had Medi-Cal coverage as secondary coverage, the hospital will submit:

- Completed TAR; and
- Verification of Medi-Cal for the dates of service.
- Complete medical record; and
- Written explanation of why the TAR is being submitted late.

Forward this documentation to:

BHSD URC Utilization Management
828 S. Bascom Avenue, Suite 200
San Jose, CA 95128
FAX: Fax: (408) 279-0806

BHSD URC will review the documentation for medical necessity, complete the TAR and submit it to Fiscal intermediary for processing. The BHSD Medical Director will notify the hospital in writing within fourteen (14) days of receipt of the completed record if any days of the admission are not authorized for payment.

L. Medicare/Private Insurance

Submit Evidence of billing.

15. DENIALS AND NOTICE OF ADVERSE BENEFIT DETERMINATION (NOABD)

A. Denials

Administrative Denial. Include the following:

1. Missing physician or provider signature and/or date.
2. Incomplete or incorrect information in the TAR fields.
3. Discrepancy between dates of service and days requested. Note: the day of discharge is not eligible for payment request.
4. Incomplete or incorrect diagnostic code.
5. TARS not submitted in a timely manner.

Clinical Denial. Clinical denials are based the patient record not meeting Title 9 §1820.205 Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient Hospital Services. If URC has previously authorized service dates for the recipient's admission but considers continuation of stay not to be medically necessary, BHSD will deny an extension of hospital stay.

Clinical denials are based on the patient record not meeting Title 9 Medical Necessity Criteria. It is therefore in the provider's best interest to ensure that documentation is complete and accurate so that the URC may make a timely and appropriate authorization decision.

Incomplete TARs will be returned with a request for correction, or a new TAR may be requested that provides all necessary information to allow BHSD URC to process the TAR.

TARs which show days not authorized by the URC through initial and retrospective reviews will be denied in part or entirely, unless additional clinical information submitted with the TARs supports the medical necessity for the days requested.

All denials are reviewed by the BHSD Medical Director or other designated physician.

Decisions to approve, modify, or deny provider requests for authorization retrospective with the provision of SMHS to beneficiaries will be communicated to the beneficiary's' treating providers, including both the hospital, and treating physician, in writing, within 24 hours of the decision.

B. Notice of Adverse Benefit Determination (NOABD)

A Notice of Adverse Benefit Determination (NOABD) is a required document that is given to Medi-Cal beneficiaries informing them of denial, terminations, reductions, or modifications of requested mental health services from BHSD and their right to appeal. BHSD Policy #415-820 Notice of Adverse Benefit Determination.

Behavioral Health Services Department (BHSD) is required to issue a Notice of Adverse Benefit Determination (NOABD) to Beneficiaries when a County, Certified Contracted Provider, Organizational Provider or BHSD Administration determines an action needs to be taken which meets criteria for an Adverse Benefit Determination regarding a Beneficiary's Specialty Mental Health Services (SMHS).

Patients with secondary coverage may also receive other types of notices of non-coverage.

BHSD will issue NOABD's to both the Beneficiary and the Facility when an NOABD relates to inpatient services. The following table describes the types of NOABD's BHSD may issue.

NOABD Type	When BHSD will use
Denial of Authorization for Requested Services	Use this template when the Plan denies a request for a service. Denials include determinations based on type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. **For DMC-ODS use this template for denied residential service requests.** **Send within two (2) business days of the decision.**
Payment Denial	Use this template when the Plan denies, in whole or in part, for any reason, a County or Certified Contracted Provider's request for payment for a service that has already been delivered to a Beneficiary. This notice reads "this is not a bill" so that the Beneficiary knows that they are not responsible for the cost of the service rendered, but that the service request has been retroactively denied. **At the time of the action. Communicate the decision to affected** County or Certified Contracted **Provider within twenty-four (24) hours of making the decision.**
Delivery System	Use this template when the Plan or BHSD County or Certified Contracted Provider has determined that the Beneficiary does not meet the criteria to be eligible for specialty mental health or substance use disorder services through the Plan. The Beneficiary will be referred to the Managed Care Plan, or other appropriate system, for mental health, substance use disorder, or other services. **Send within two (2) business days of the decision.**
Modification	Use this template when the Plan or BHSD County or Certified Contracted Provider modifies or limits a provider's request for a service, including reductions in frequency and/or duration of services, and approval of alternative treatments and services. **Send within 2 business days of the decision.**
Termination	Use this template when the Plan or BHSD Provider terminates, reduces, or suspends a previously authorized service. **Beneficiaries must request Aid Paid Pending within ten (10) days of date of NOABD or before the effective date, to continue services while the appeal is pending.** **Send at least 10 days before the date of Action.**
Delay in Processing Authorization of Services	Use this template when there is a delay in processing a County or Certified Contracted Provider's request for authorization of SMHS or for **DMC-ODS substance use disorder residential services**. When the Plan extends the timeframe to make an authorization decision, it is a delay in processing a County or Certified Contracted Provider's request. This includes extensions granted at the request of the Beneficiary or County or Certified Contracted Provider, and/or those granted when there is a need for additional information from the Beneficiary or County or

	Certified Contracted Provider, when the extension is in the Beneficiary's interest. **At the time of the action.**
Timely Access	Use this template when there is a delay in providing the Beneficiary with timely services, as required by the timely access standards applicable to the delayed service. **Send within two (2) business days of the decision.**
Financial Liability	Use this template when the Plan or BHSD County or Certified Contracted Provider denies a Beneficiary's request to dispute financial liability, including cost-sharing and other Beneficiary financial liabilities. **At the time of the action.**
Failure to Timely Resolve Grievances and Appeals	Use this template when the Plan or BHSD County or Certified Contracting Provider does not meet required timeframes for the standard Resolution of Grievances and Appeals. **Send within two (2) business days of the decision.**

NOTE: *Notices of Adverse Benefit Determination do not need to be issued if the services do not require authorization or if the Beneficiary agrees with the decision*

16. APPEALS

A. Provider Appeals Process

If you disagree with a decision made by the BHSD, follow the processes outlined on the NOABD to contact us with your concerns. We want to resolve issues at the lowest level possible. Providers are encouraged to communicate any issue or concern regarding clinical decisions or claims and billing procedures Grievance and Appeals System Oversight Process outlined in BHSD Policy #415-819.

All provider problem resolution and appeals processing are governed by Title 9, CCR, Chapter 11, and §1850.305. Please contact the assigned Quality Improvement Coordinator if you have any questions regarding the timelines or regulation of the process.

B. Expedited Requests

Request to utilize the expedited requests process should be limited to those patients that are currently in the level of care under discussion. If the patient has been discharged from that level of care, the provider will be directed to use the grievance and appeals oversight process. **Appendix 9.**

Expedited requests are coordinated through the BHSD Medical Director or Designee.

Confirmatory documentation of the clinical aspects discussed during the expedited review will be requested. Since authorization determinations are made on available documentation, progress notes, nursing notes, etc. will be requested. This discussion may result in:

- Reconsideration of the initial decision, and a negotiated resolution.
- An expedited peer-to-peer review between the BHSD Medical Director or designee and the treating psychiatrist.

C. Level I Appeal

The provider may request a Level I Appeal by submitting a written request on their letterhead to BHSD URC for a review within ninety (90) calendar days of the date of receipt of a denial of reimbursement. The request must be written by an authorized representative at the facility. The document submitted for review must be the original. The provider must include in writing all relevant data, documents or comments that support the medical necessity criteria for the provided services. **Appendix 10.** This information is to include, but is not limited to, the following:

- Any documentation supporting allegations of timeliness, if at issue, including fax records, phone records or memos.
- Clinical records supporting the existence of medical necessity, if at issue.
- A summary of the reasons why the services should have been authorized.
- Provider's name, address, and phone number.
- Signature of authorized provider representative.

An original Level I Appeal should be mailed to:

Inpatient Utilization Review Coordinator (URC)
828 S. Bascom Avenue, Suite 200
San Jose, CA 95128

A BHSD psychiatrist not involved with the initial denial of payment will review the information and prepare a written response to be sent back to the provider within sixty (60) calendar days of the receipt of the appeal.

If the denial of payment is upheld, the provider may initiate a Level II appeal.

TAR Appeal Timelines

F I R S T L E V E L

Provider has **ninety (90) days** after notification of denied days to appeal to the BHSD URC.

BHSD has **sixty (60) days** after receiving appeal documents to respond to the provider.

S E C O N D L E V E L

If the first level appeal is not fully approved, the provider has **thirty (30) days** after notification to send a 2nd Level Appeal to the State

State has **seven (7) days** to request documentation from BHSD

BHSD has **twenty one (21) days** to send documents supporting denial of appeal to the State

State has **sixty (60) days** to notify the Provider and BHSD of the decision to uphold or reverse the BHSD decision

If days are approved at the 2nd Level, provider has **thirty (30) days** to submit a TAR to BHSD.

After receiving the 2nd Level TAR, BHSD has **fourteen (14) days** to send the TAR to the Fiscal Intermediary and the provider

D. Level II Appeal

In the event that the denial of payment is upheld at the Level I Appeal, the provider is notified of the right to a Level II Appeal. A Level II Appeal is submitted to the State Department of Health Care Services Hearing Officer. The appeal must be filed in writing, along with supporting documentation, within thirty (30) calendar days of BHSD URC written notification of the Level I appeal decision.

The appeal and supporting documentation should be sent to:

Department of Health Care Services
Mental Health Services Division
1500 Capitol Avenue, Suite 72.442, MS 2703
Sacramento, CA 95814
Phone: (916) 319-0985

The State DHCS Hearing Officer will notify BHSD URC and the provider of its receipt of a request for appeal within seven (7) calendar days and ask for specific documentation supporting the MHPs decision to deny payment.

BHSD URC will submit the required documentation within twenty one (21) calendar days of notification of the appeal or the State DHCS shall find the appeal in favor of the provider.

The State DHCS shall have sixty calendar (60) days from the receipt of the MHPs documentation to notify the provider and the MHP in writing of the decision and its basis.

If the State DHCS does not respond within sixty calendar (60) days from the postmark date of the MHPs documentation, the appeal shall be deemed upheld.

As of June 30, 2003, if the State DHCS upholds the original decision to deny reimbursement, a review fee will be assessed to the provider (DM11 Letter #03-07).

If the State DHCS overturns a provider appeal, the provider is notified in writing with instructions to submit a new TAR to BHSD URC. BHSD URC has fourteen (14) calendar days from the receipt date of the provider's new TAR to authorize payment and submit to the state's fiscal intermediary for processing.

17. CONFIDENTIALITY & COORDINATION OF CARE

In accordance with State and Federal regulations, and within the guidelines of Santa Clara County Behavioral Health Services Department policies regarding confidentiality and release of information, hospital providers are expected to coordinate care with other healthcare and mental health providers who are also serving their patients.

Information may be released without written permission when it will be used for diagnosis and treatment purposes, on an as needed basis. This allowance is based on Civil Code § 56.10 which states that: "A provider of healthcare or a health care services plan may disclose medical information to providers of healthcare, healthcare services plans, or other healthcare professional or Inpatient Psychiatric Facilities for purposes of diagnosis or treatment of the patient."
Cite Policy

A. Outpatient Coordination of Care

Care Coordinator/Case Manager: Patients who are already involved or have recently been involved in the Specialty Mental Health Care System, in many cases, have a Care Coordinator. A Care Coordinator, such as a clinic therapist or an intensive case manager, is the person assigned to each individual patient who is responsible for ensuring that the patient receives all needed services. The Care Coordinator is responsible for integrating the patient's treatment and care and assists the patient in obtaining needed services both within and outside the organization. In order to coordinate care at the time of an inpatient admission, hospital staff should make an effort to obtain information regarding the patient's assigned Care Coordinator. To identify if a patient has an outpatient care coordinator you can contact the BHSD Call Center any time.

BHSD Call Center
(800) 704-0900

The Outpatient Care Coordinator/Case Manager should be contacted within 24 hours of admission to the inpatient setting.

The Center for Medicare and Medicaid Services has established Core Measures that identify three long-term goals related to care coordination:

1. Improve the quality of care transitions and communications across care settings.
2. Improve the quality of life for patients with chronic illness and disability by following a current care plan that anticipates and addresses pain and symptom management, psychosocial needs, and functional status.
3. Establish shared accountability and integration of communities and health care systems to improve quality of care and reduce health disparities.

The goal of care coordination is to create a delivery system that is less fragmented and more organized, where handoffs are clear, and patients and clinicians have the information they need to optimize the patient-clinician partnership (NQS, 2011). When all of a patient's health care providers coordinate their efforts, it helps ensure that the patient receives appropriate care and support, when and how the patient needs and wants it. Effective care coordination models, such as patient-centered medical homes, have begun to show that they can deliver better quality care at lower costs in settings that range from small physician practices to large hospital centers.

The type of information hospital staff may share with the Care Coordinator/Case Manager should include, but not be limited to:

- Date of admission.
- Circumstances of admission.
- Medication, and any changes in medication.
- Notification of any certification hearings or plans regarding Conservatorship.
- Discharge planning.
- Date planned discharge.
- Notification of patient leaving hospital AMA.

In order to ensure that the patient will receive continuity of care between providers of all services, the Care Coordinator/Case Manager will interact with hospital staff by participating in the following ways:

- Communicating with hospital staff about patient's treatment.
- Reviewing the discharge plan with hospital staff and assisting with the discharge plan when appropriate.
- Assisting to ensure that the patient is seen by a mental health care professional within 72 hours of discharge from the hospital.

In addition, it is very useful for the Care Coordinator /Case Manager to participate in and receive a copy of the patient's discharge plan.

If you are unable to reach the Care Coordinator/Case Manager or a clinical representative from the patient's outpatient provider, contact the appropriate Hospital Liaison to discuss coordination of care options.

Santa Clara County Family & Children's Division
Hospital Liaison
Phone: (408) 794-0760
After Hours Phone: (408) 483-8030
FAX: (408) 938-4529

Santa Clara County Adult Older Adult Division
Hospital Liaison
Phone: (408) 885-3679
FAX: (408) 885-5789

If the patient does not have a current provider, contact the BHSD Call Center (800) 704-0900 to establish a referral for services to begin within five (5) business days of discharge.

B. Conservatorship Coordination

If the patient is conserved, the facility must contact the Conservator's Office:

1. To obtain consent for treatment
2. Report post emergency medications
3. Unusual Occurrences

4. Diagnoses

Office of the Public Guardian
PO box 760
San Jose, CA 95106
Phone **(408) 755-7610**
(Administration) (408) 577-2523
FAX (408) 577-2500

C. Discharge Planning

In order to facilitate continued treatment and prevent re-admission, discharge plans shall be completed for all patients being discharged from an acute level of care. Planning for discharge shall begin on the day of admission. Discharge planning shall include:

- For Cal Medi-Connect patients, contact the Cal Medi-Connect Managed Care Plan.
- Contact with the patient's Care Coordinator within 24 hours of admission
- Planning for appropriate living arrangements for the patient upon discharge
- Planning for discharge to the appropriate level of care, including organizational, residential, or outpatient providers
- Consideration of prior failures and successes of the patient in an effort to design an effective discharge plan
- Contacting an outpatient provider and requesting an appointment for providers and programs that schedule appointments (such as children's programs) to be scheduled for the patient as soon as possible, or a referral to a walk-in program, with the targeted goal that the patient is seen within five (5) business days of the patient's discharge from the facility
- Requesting a Release of Information (ROI) from the patient to facilitate coordination of care between the acute setting and the outpatient provider (an ROI is not required for coordination, diagnosis, or treatment purposes; however, it is a good practice and helps the patient be more actively involved in their care)
- Sending fax to the referral program with the information about the patient that has been referred in order to ensure that the program is aware that the patient is coming
- Collaborating with Hospital Liaison regarding discharge coordination and with 24 Hour Care for coordination of placement
- Providing to the Outpatient Service Team the Aftercare Plan within twenty-four (24) hours of discharge and the Discharge Summary within fourteen (14) calendar days of discharge for continuity of care
- Identifying plan for patient to obtain medications after discharge
- Coordinating family meeting, if appropriate
- Contacting the Conservator, if applicable
- For patients being served through Primary Care Behavioral Health Services, a Specialty Mental Health Services referral is required.

BHSD URC staff review the discharge planning progress during the clinical record review process.

18. BENEFICIARY RIGHTS

Santa Clara County BHSD is committed to protecting patient's rights in accordance with State and Federal Regulations and County policy. Violations of beneficiary rights will be responded to appropriately. Contracted inpatient psychiatric facilities are required to offer BHSD materials related to patient rights to patients at admission and in common patient areas at the facility. Beneficiary rights include:

Welfare and Institutions Code §5325.1 RIGHTS

(a) A right to treatment services which promote the potential of the person to function independently. Treatment should be provided in ways that are least restrictive of the personal liberty of the individual.

(b) A right to dignity, privacy, and humane care.

(c) A right to be free from harm, including unnecessary or excessive physical restraint, isolation, medication, abuse, or neglect. Medication shall not be used as punishment, for the convenience of staff, as a substitute for program, or in quantities that interfere with the treatment program.

(d) A right to prompt medical care and treatment.

(e) A right to religious freedom and practice.

(f) A right to participate in appropriate programs of publicly supported education.

(g) A right to social interaction and participation in community activities.

(h) A right to physical exercise and recreational opportunities.

(i) A right to be free from hazardous procedures.

Welfare and Institutions Code §5325 RIGHTS

(a) To wear his or her own clothes; to keep and use his or her own personal possessions including his or her toilet articles; and to keep and be allowed to spend a reasonable sum of his or her own money for canteen expenses and small purchases.

(b) To have access to individual storage space for his or her private use.

(c) To see visitors each day.

(d) To have reasonable access to telephones, both to make and receive confidential calls or to have such calls made for them.

(e) To have ready access to letter writing materials, including stamps, and to mail and receive unopened correspondence.

(f) To refuse convulsive treatment…

(g) To refuse psychosurgery…

(h) To see and receive the services of a patient advocate who has no direct or indirect clinical or administrative responsibility for the person receiving mental health services.

(i) Other rights, as specified by regulation.

A. Confidentiality

Maintaining the confidentiality of patient and family information is of vital importance, not only to meet legal mandates, but also as a fundamental trust inherent in the sensitive nature of the services provided through the MHP.

B. Patient Handbooks

Providers are required to give each patient a Patient Handbook at the patient's admission, on request and readily available to patients in common areas at the facility. The handbook is entitled: Santa Clara County – Guide to Medi-Cal Mental Health Services. The beneficiary handbooks contain a description of the services available through the MHP, a description of the required process for obtaining services, a description of the MHP problem resolution process, including the complaint resolution and grievance and appeal processes and a description of the beneficiary's right to request a State fair hearing. Guides are written by the State with updates by the MHP. The guide is found on our website at:

https://bhsd.sccgov.org/sites/g/files/exjcpb711/files/scc-mhp-english-beneficiary-handbook.pdf

Inpatient Psychiatric Facilities must have copies of the Guide and other state required materials in all the Santa Clara County Threshold Languages- Chinese, English, Spanish, Tagalog, Farsi, and Vietnamese. Area of Concentration Standard Languages may also apply of the patient resides in a region where the language may not meet Threshold Criteria, but it meets Concentration Language criteria.

All patients also must receive a copy of the State Handbook, Rights for Individuals in Mental Health Inpatient Psychiatric Facilities. This handbook deals with rights of persons both voluntarily and involuntarily admitted, discussing the role of the Patient Rights Advocate, rights that cannot be denied, rights that can be denied with good cause, medical treatment, and the right to refuse it, and informed consent for medication.

The Rights for Individuals in Mental Health Inpatient Psychiatric Facilities can be found in ten (10) different languages at the site below:

http://www.dhcs.ca.gov/services/Pages/Office-of-Patients-Rights.aspx

C. Translation Service Availability

According to California Code of Regulation (CCR) Title 9 and Federal Regulation, Title IV of the Civil Rights Act of 1964, interpreter services shall be available to beneficiaries and families in threshold and non-threshold languages if requested or if the need is determined to assist in the delivery of specialty mental health services. It is not the standard of practice to rely on family members for translation services.

D. Patient Grievances and Appeals

- Call or file a grievance with BHSD:

  Quality Assurance Program
  P.O. Box 28504
  San Jose, CA 95159
  Phone: (800) 704-0900
  FAX: (408) 288-6113

  Contracted providers are required to have BHSD Grievance and Appeal forms, pre-paid and pre-addressed envelopes are available in common areas and on request at their facility.

- Who else can help me? Contact:

  Mental Health Advocacy Project
  Phone: (800) 248-MHAP
  Phone: (408) 294-9730
  FAX: (408) 350-1158

  Patients may contact the Mental Health Advocacy Project (MHAP) if they are dissatisfied with any aspect of inpatient services, they receive under BHSD.

https://bhsd.sccgov.org/information-resources/grievance-appeal

It is the provider's responsibility to inform patients regarding their right to file a grievance or an appeal to express dissatisfaction with BHSD services without negative consequences of any kind. Providers are required by Title 9 to post Grievance and Appeal posters (in English and the State DHCS designated threshold and area of concentration standard languages which for Santa Clara County) in a visible area to ensure patients are advised of their rights. Title 9 requires brochures are available to both patients and provider staff without the need of a verbal or written request by the patient. Copies of the Grievance and Appeal Forms are available on the BHSD website:

https://bhsd.sccgov.org/information-resources/grievance-appeal

Inpatient providers are required by Title 9 to maintain a log in which all patient or family concerns or grievances are entered. Concerns may be expressed verbally or in writing. The log must include the following elements:

- Complainant's name
- Date the grievance was received
- Name of person logging the grievance
- Nature of the grievance
- Nature of the grievance resolution
- Date of resolution

BHSD may request a copy of a provider's Grievance Log at any time.

E. Patient Right to Request a State Fair Hearing

Patients have the right to request a fair hearing any time before, during or within 90 days after the completion of the beneficiary problem resolution process, whether or not the patient uses the problem resolution process and whether or not the patient has received a Notice of Adverse Benefit Determination (NOABD). Providers are required to inform their patients or the patients' conservators/legal guardians of these rights.

F. Patient Right to Have an Advance Health Care Directive

All new patients must be provided with the information regarding the right to have an Advance Health Care Directive at their first face-to-face contact for services. This procedure applies to emancipated minors and patients 18 years and older. Generally, Advance Directives address how physical health care should be provided when a patient is incapacitated by a serious physical health care condition, such as a stroke or coma, and unable to make medical treatment decisions for them. All patients have the right to receive assistance and prepare psychiatric advance directives prior to a crisis. The packets below include instructions and an advanced directives document that addresses physical and mental health.

Instructions and Form:

(English) http://www.disabilityrightsca.org/pubs/508801.pdf

(Spanish) Directivas anticipadas de atención de la salud | Disability Rights California

Advance Health Care Directives for Mental Health – A Trainer's Manual:

(English) Advance Health Care Directives for Mental Health - A Trainer's Manual (disabilityrightsca.org)

Training:

[Webinar: Understanding Advance Health Care Directives | Disability Rights California]

G. Title 42 CFR § 438.100 – Addressing Beneficiary's Rights

(1) General rule. The State must ensure that—

- (i.) Each Medicaid Plan (paraphrase) has written policies regarding the enrollee rights specified in this section; and
- (ii.) Each Medicaid Plan (paraphrase) complies with any applicable Federal and State laws that pertain to enrollee rights and ensures that its staff and affiliated providers take those rights into account when furnishing services to enrollees.

(2) Specific rights—

- (i.) Basic requirement. The State must ensure that each Medicaid enrollee (paraphrase) is guaranteed the rights as specified in paragraphs (b) (2) and (b) (3) of this section.
- (ii.) Medicaid enrollees (paraphrase)have the following rights: The right to—
  - a. Receive information in accordance with §438.10.
  - b. Be treated with respect and with due consideration for his or her dignity and privacy.
  - c. Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand. (The information requirements for services that are not covered under the contract because of moral or religious objections are set forth in §438.10(g) (2) (ii) (A) and (B).
  - d. Participate in decisions regarding his or her health care, including the right to refuse treatment.
  - e. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.
  - f. If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and 164.526.
  - g. Medicaid enrollees (paraphrase) have the right to be furnished health care services in accordance with §§438.206 through 438.210.

(3) Free exercise of rights. The State must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the Medicaid Plan (paraphrase) and its providers or the State agency treat the enrollee.

(4) Compliance with other Federal and State laws. The State must ensure that each Medicaid Plan (paraphrase) complies with any other applicable Federal and State laws (such as: title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; and Titles II and III of the Americans with

Disabilities Act; and § 1557 of the Patient Protection and Affordable Care Act, as well as other laws regarding privacy and confidentiality).

19. QUALITY IMPROVEMENT

LPS Designated Facility Site reviews will be conducted tri-annually. Requirements are based on State standards for Medi-Cal certification. On-site reviews shall occur during normal business hours with at least 72-hours prior notice; except unannounced on-site reviews and requests for information may be made in those exceptional situations where arrangement of an appointment beforehand is clearly not possible or clearly inappropriate due to the nature of the intended visit.

Providers are required to adhere to all applicable federal, State, and County regulations, policies, and statutes, including Title 9 and DMH Letters and Notices.

Providers are required to conduct patient satisfaction surveys.

All County and contracted providers are required to report serious incidents involving patients in active treatment. Required reports shall be sent to the BHSD Quality Assurance Division.

All mental health providers are required to adhere to cultural competence standards. The QI staff will look for elements of cultural competence in program orientations, staffing, charting and/or trainings during site reviews.

All Lanterman-Petris-Short (LPS) designated Inpatient Psychiatric Facilities are required by the State DHCS to submit the following quarterly reports to Quality Assurance Division, using the State forms included in the Appendix:

- Denial of Rights/Seclusion and Restraint (MH 308)—if there are no instances of denied rights in a quarter, hospitals must submit a report saying this.
- Quarterly Report on Involuntary Detentions (MH 3825) —not required for non Lanterman-Petris-Short LPS Inpatient Psychiatric Facilities.
- Convulsive Treatment Administered—to include Outpatient ECTs.

These reports should be submitted to the QA Division by the 5th day after the end of the quarter. Forms have been provided, both in hard copy and electronically.

Please note that because of HIPAA confidentiality requirements completed forms containing patient identifiers are not allowed to be electronically submitted. These reports can be mailed or faxed to the QA Division confidential fax at (408) 288-6113.

20. QUALITY OF CARE STANDARDS

Psychiatric inpatient providers shall be committed to providing dignified care and treatment to patients who struggle with mental illness and substance abuse. Providers shall strive to restore the patient to optimal functioning in the shortest amount of time

and in the least restrictive and most comfortable environment possible. Providers will involve the patient's natural support system and include them in their treatment planning and care. Providers shall understand that it is common for people with mental illness to experience stigma and barriers to social integration and shall be committed to eliminating stigma and to promoting the fullest recovery for each patient.

Psychiatric inpatient Providers shall abide by their respective discipline's guidelines such as those noted on the following websites.

- CA Psychiatric Association www.calpsych.org/
- American Psychiatric Nurses Association- CA Chapter www.apnaca.org
- National Association of Social Workers- CA www.naswca.org/
- CA Association of Marriage and Family Therapists www.camft.org/
- California Psychological Association www.cpapsych.org/

APPENDIX 1: Documentation Requirements

Medical Necessity

Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services. (Excerpt from 9 CCR §1830.205 Provision of Services.)

Patients MUST meet the following criteria:

- Patient meets Title 9 Medical Necessity criteria for hospitalization
- Medical record documentation sufficiently justifies Medical Necessity for hospitalization admission and continued stay
-

Medical Necessity for Medi-Cal Specialty Mental Health Services

- Medical Necessity and Functional Impairments must be determined and documented throughout the assessment.
- The assessment must identify that behavioral symptoms of the most current DSM included diagnosis.
- The symptoms are serious enough to disrupt the client's ability to cope with or master various age and culture related social, personal safety, occupational or behavioral role functions.

Document Medical Necessity by...

- Stating target symptoms and diagnosis stating the level and severity of impairment and its relationship to the included diagnosis.
- Stating the level and severity of disruption of social and other role functions that are due to symptoms from the included diagnosis.
- Describing how the interventions are reducing either the impairment of functioning or the symptoms that are causing impairment in functioning.
- Stating the focus of treatment as evident by choice of goals/objectives and addressing these goals and objectives in progress notes.

Functional Impairment Evaluation

Pertains to the client's quality of life and whether the client's mental illness impacts this quality of life in the following areas:

- Living situation
- Daily activities and functioning
- Family relations
- Social relations
- Finances
- Legal and safety issues
- Work and school
- Health
- Cultural components
- Potential for exploitation

The Clinical Pathway to Determine and Document Medical Necessity

1. Comprehensive Assessment
2. Clinical Formulation for Medical necessity
3. Treatment Plan of Care includes goals/objectives based on Behaviors/Symptoms that determined Medical Necessity
4. Document behavioral changes and progress towards goals/objectives based on Medical Necessity

Acute Day Services

Acute day services are hospital provided services and equipment that meet medical necessity criteria and are required for diagnosis and treatment of a beneficiary's mental disorder.

Administrative Day Services

MHSUDS Information Notice 19-026. Authorization of Specialty Mental Health Services

> A hospital may claim for administrative day services when a beneficiary no longer meets medical necessity criteria for acute psychiatric hospital services but has not yet been accepted for placement at a non-acute residential treatment facility in a reasonable geographic area. The MHP shall review that the hospital has documented having made at least one contact to a non-acute residential treatment facility per day (except weekends and holidays), starting with the day the beneficiary is placed on administrative day status. Once five contacts have been made and documented, any remaining days within the seven-consecutive-day period from the day the beneficiary is placed on administrative day status can be authorized. A hospital may make more than one contact on any given day within the seven-consecutive-day period; however, the hospital will not receive authorization for the days in which a contact has not been made until and unless all five required contacts are completed and documented. Once the five-contact requirement is met, any remaining days within the seven-day period can be authorized without a contact having been made and documented.
>
> MHPs may waive the requirements of five contacts per week if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options for the beneficiary. The lack of appropriate, non-acute treatment facilities and the contacts made at appropriate facilities shall be documented to include the status of the placement, date of the contact, and the signature of the person making the contact.
>
> Examples of appropriate placement status options include, but may not be limited to, the following:

- The beneficiary's information packet is under review.
- An interview with the beneficiary has been scheduled for [date].
- No bed available at the non-acute treatment facility.
- The beneficiary has been put on a wait list.
- The beneficiary has been accepted and will be discharged to a facility on [date of discharge].
- The patient has been rejected from a facility due to [reason].
- And/or a conservator deems the facility to be inappropriate for placement.

- Administrative day services are hospital services provided to a patient whose stay continues beyond the patient's need for acute services due to a temporary lack of appropriate residential treatment placement options. The following are Administrative Day requirements:
    - The chart note label identifies it as a note documenting discharge planning and/or placement activity, such as "Discharge Planning, Case Management, or Social Services."
    - The patient previously met medical necessity criteria for acute psychiatric inpatient hospital services for at least one day during the stay. CCR, Title 9, Chapter 11, §§ 1820.220(j) (5) and 1820.225(d) (2).
- Immediate placement in an appropriate, non-acute residential treatment facility within a reasonable geographic area is unavailable, and the hospital documents contact with a minimum of five (5) appropriate, non-acute residential treatment facilities per week subject to the following:
    1. URC may waive the five contact requirements if there are fewer than five appropriate non-acute treatment facilities available. If fewer than five (5) facilities are documented as unavailable, at least one contact per week is required.
    2. Documentation on all contact calls to appropriate, non-acute treatment facilities must include:
        a) Contact dates
        b) Facility name, and the name and telephone number of the person the discharge planner contacts (busy signals, no answer, messages left with an answering service or on a machine are not considered contacts).
        c) Placement option(s) status
        d) Signature of the person making each contact (CCR, Title 9, Chapter 11, §§ 1820.220(j)(5) and 1820.225(d)(2)).
    3. There must be at least one appropriate placement call made on the first day of requested Administrative Days.
    4. A board and care placement search must be for an augmented board and care per State requirement
    5. It is unacceptable keeping a hospitalized patient waiting for a specific board and care if placement is available at another location. The hospital is responsible for continuing the search for other placement options during the waiting period between pending bed discovery and placement.
    6. A minimum of one documented placement contact must occur on the day the facility/hospital orders Administrative Day designation for patients

discharged to an Institution for Mental Diseases (IMD), It is required that subsequent searches be conducted and documented within the same first week.

7. It is necessary to note follow-up at every contacted facility to determine status: noting acceptance or denial of the patient for that day's contact.

APPENDIX 2: The Language We Use

Here are a few examples of behaviorally non-specific words and phrases and their behaviorally specific counterparts. * DHCS

We write this	This would be better…
Impulsive	Acts without anticipating consequences as exhibited by grabbing items from other patients' hands.
Aggressive	Shoved other patients out of the cafeteria line so that he could be served first.
Postured Aggressively	Shook a closed fist in the therapist's face.
Threatening	She said, "If you ask me another questions, I will slap you."
Hostile	He shouted, "go to hell" when he was asked to join the therapy group.
Homicidal Ideation (+HI)	Describe the ideation. Is it passive or active? Is it directed at a particular person? Is it directed at an identifiable group of people? Is it accompanied by homicidal intent? Is there a specific plan? Opportunity? Means? Timing?
Danger to Others (+DTO)	Describe the specific behaviors that constitute +DTO
Labile	Describe different mood states, how quickly they alternate, whether there are triggers for the alternations, etc.
Sullen	When greeted the patient stared intently back at me. When asked how he felt, he said, "I hate it here."
Sexually Inappropriate	The patient began masturbating in the dayroom.
Disruptive	She frequently interrupted the group leader and other participants, shouting her thoughts and reactions.
Suicidal, Suicidal Ideation (+SI)	Describe. Is there ideation? Is the ideation Passive or Active? Is there Intent? Does the patient have a specific plan? Does the patient have means or opportunities?
Danger to Self (+DTS)	What specific behaviors constitute +DTS?
Self-Injurious Behavior (+SIB)	Describe specific types of self-injurious behavior. What were the medical consequences?
Despondent	The patient said, "I feel there is no hope for me. There is nothing I can do to change my life."
Psychotic	Appears preoccupied with listening to voices. Frequently shouts in response to what she hears.
Disorganized	In what specific ways is the patient being disorganized? Example – Patient smears feces on walls of his bathroom.

We write this	This would be better…
Command Auditory Hallucinations (+CAH)	Describe what are the voices commanding patient to do? Is patient able to resist obeying the commands?

Poor ADLs	Refuses to brush teeth. Has not showered in x 2 days. Describe reasons for the behaviors. E.g., are poor ADLs secondary to skill deficits, delusional beliefs, social phobia…
Paranoid	Describe the specific behaviors/statements which cause the writer to describe the patient as “paranoid.”
Regressed	“Patient refused to put on clothing, and continued to sit, rocking back and forth in the corner of his room.”
Unpredictable	In what specific ways has the patient exhibited “unpredictable” behavior. E.G., “The patient walked up to the counter at the nursing station and shoved the computer onto the floor.”
+ Poor Coping Skills	Describe both the specific behaviors which lead to the inference that there are “poor coping skills,” as well as the circumstances in which the deficits have been observed.
Gravely Disabled (+GD)	What observable behaviors constitute “+GD”. Simply being unable to formulate and/or execute a plan for self-care does not constitute being gravely disabled.
Blowing Up	What exactly did the patient do? For example, “He overturned the medication cart and punched a mental health worker in the mouth with a closed fist.

APPENDIX 3: Glossary

Term	Definition
5150/5585.50	Sections of the California Welfare and Institutions Code (WIC) that authorize professionals with involuntary detention authority to take individuals into custody for a period of up to 72 hours for assessment, evaluation, crisis intervention, or placement for evaluation and treatment in a Designated Facility if they are a danger to self, danger to others, or gravely disabled due to mental health disorder.
Acknowledgement Letter	Letter provided within five (5) working days of the Date of Receipt of a Beneficiary Grievance or Provider Dispute. The letter shall advise Beneficiary and/or Provider of the Grievance that has been received, the date of receipt and provide the name, telephone number and address of the Representative who may be contacted about the Grievance. The Acknowledgement Letter informs Beneficiaries/Providers of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments for an Expedited Appeal sufficiently in advance of the Resolution timeframe for the Expedited Appeal.
Acute Settings	Settings that treat individuals who require immediate intervention and are at risk for further decompensation, danger to self or others, or grave disability.
Administrative Denial	An Administrative Denial includes the following: 1. Missing physician or provider signature and/or date 2. Incomplete or incorrect information in the TAR fields. Note: the day of discharge is not eligible for payment request. 3. Discrepancy between dates of service and days requested. Note: the day of discharge is not eligible for payment request. 4. Incomplete or incorrect diagnostic code 5. TARS not submitted in a timely manner
Adverse Benefit Determination	Means any of the following actions taken by a Plan: 1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit. 2. The reduction, suspension, or termination of a previously authorized service. 3. The denial, in whole or in part, of payment for a service. 4. The failure to provide services in a timely manner.

	5. The failure to act within the required timeframes for standard Resolution of grievances and appeals. 6. The denial of a Beneficiary's request to dispute financial liability.
Aid Paid Pending (APP)	Medi-Cal Beneficiaries who have filed a timely request can have their existing benefits continue while an appeal or State Hearing are pending. Timely means if a Beneficiary requests an appeal within ten (10) calendar days of the date on the Notice of Adverse Benefit Determination (NOABD) or the date of the intended effective date of the BHSD proposed Adverse Benefit Determination. BHSD and the BHSD County or Certified Contracting Provider must continue all services if all of the following occur: a) The Beneficiary files a timely request for appeal. b) The appeal involves a termination, suspension, or reduction of an existing service authorization. c) Which has not lapsed. d) Beneficiary has timely filed for a continuation of services. If, at the Beneficiary's request, BHSD continues or reinstates the Beneficiary's existing services, services must continue until the one of the following occurs: a) The Beneficiary withdraws the appeal or request for a State Hearing. b) The Beneficiary fails to request a State Hearing and continuation of services within ten (10) calendar days after BHSD sends the Notice of Appeal Resolution (NAR) upholding the Adverse Benefit Determination. c) The State Hearing sends a NAR upholding the Adverse Benefit Determination. d) The State Hearing issues a hearing decision adverse to the Beneficiary. Beneficiaries shall be informed that they may be held liable for the cost of those services if the State Hearing upholds the BHSD Adverse Benefit Determination.
Appeal	An Appeal is a Plan review of a Notice of Adverse Benefit Determination (NOABD). A request for review of an Action, in response to a problem, such as denial or changes to services a Beneficiary believes they need. The Appeal may be filed in person, on the phone, or in writing. However, Appeals must be signed by the Beneficiary or by the Participating Provider on behalf of the Beneficiary. A process to have an authorization decision that adversely affects services provided to an individual, or involves denial of services to an individual, reviewed by a licensed professional to

	evaluate the medical needs or the individual and not in the original denial decision, to evaluate the medical needs of the individual for possible decision reversal.
Beneficiary	A person seeking or receiving behavioral health services from BHSD that is either a person certified as eligible for Medi-Cal or Medicare services, or someone for whom there is no third-party payor who may become responsible for paying all or part of the person's medically necessary behavioral health services.
California Department of Public Health (CDPH)	The state department responsible for public health in California. It is a subdivision of the California Health and Human Services Agency. It enforces some of the laws in the California Health and Safety Codes, notably the licensing of some types of healthcare facilities.
Clinical Denial	Clinical denials are based the patient record not meeting Title 9 §1820. 205 Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient Hospital Services. If URC has previously authorized service dates for the recipient's admission but considers continuation of stay not to be medically necessary, BHSD will deny an extension of hospital stay.
Concurrent Authorization	Required for Crisis Residential Treatment Services, psychiatric hospital facilities and psychiatric inpatient hospital services. To ensure the appropriateness of inpatient admissions and determine the level of care and length of stay based on Medical Necessity, inpatient providers will submit a Notice of Hospitalization after the first day of admission. Plan's will process and communicate authorization determinations within 24 hours of receipt of the Notification of Hospitalization.
Concurrent Review	Concurrent review encompasses those aspects of utilization review that take place during the course of facility-based or inpatient treatment.
Conservatorship	Gives legal authority to one adult (called a conservator) to make certain decisions like consent for treatment, for a seriously mentally ill person (called a conservatee) who is unable to take care of themselves.
Continued Stay Criteria	Continued stay in an acute psychiatric inpatient hospital will only be reimbursed when a patient experience one (1) of the following: a. Continued presence of admission reimbursement

	criteria indications for psychiatric inpatient hospital services as specified in Medi-Cal Medical Necessity Criteria. b. Serious adverse reaction to medications, procedures, or therapies requiring continued hospitalization. c. Presence of new indications which meet admission reimbursement criteria. d. Need for continued medical evaluation or treatment that can only be provided if the patient remains in an acute psychiatric inpatient hospital unit.
Contract Hospital	A provider of psychiatric inpatient hospital services, which is certified by the State Department of Health Services and has a contract with a specific Mental Health Plan to provide Medi-Cal psychiatric inpatient hospital services to eligible beneficiaries.
County of Origin	The county where legal jurisdiction has been established and/or that has financial responsibility for the Medi-Cal Beneficiary.
Date of Receipt	The "date of receipt" means the date the TAR or other document was received as indicated by a date stamp made by the receiver or the fax date recorded on the document. For documents submitted by mail, the postmark date shall be used as the date of receipt in the absence of a date/time stamp made by the receiver.
Date of Service	For the purposes of evaluating claims submission and payment requirements under these regulations, means: 1. For outpatient services and all emergency services and care: the date upon which the 2. provider delivered separately billable health care services to the enrollee. 3. For inpatient services: the date upon which the enrollee was discharged from the inpatient facility. However, a Plan and a Plan's capitated provider, at a minimum, shall accept separately billable claims for inpatient services on at least a bi-weekly basis.
Denial	A determination that a specific service is not medically/clinically appropriate, necessary to meet needs, consistent with the person's diagnosis, symptoms and functional impairments, the most cost-effective option in the least restrictive environment, and/or consistent with clinical standards of care and/or per policy and contractual requirements.

Denied Service	A service requested on behalf of the Medi-Cal Beneficiary by a physician or facility. a. The requested services are Denied prior to the Beneficiary receiving the service. b. Retrospectively, an emergency admission is Denied if it does not meet medical necessity criteria for reimbursement at the time of admission as per BHSD Policy #415-101 Medical Necessity Criteria.
Department of Health Care Services (DHCS)	Department within the California Health and Human Services Agency that finances and administers a number of individual health care service delivery programs, including Medi-Cal, which provides health care services to low-income people.
Designated Facility	A facility that has been designated by the Plan Director, approved by the BOS and the State to provide involuntary psychiatric evaluation and treatment to persons that are a danger to self, danger to others, or gravely disabled due to a mental health disorder. This designation is valid up to three (3) years.
Emergency Services	Medical care provided in the emergency room of an acute care hospital. Medical Determination means the medical services that are determined by a qualified licensed practitioner as: 1. Appropriate and necessary for the symptoms, diagnosis, or treatment of medical condition. 2. Within recognized standards of medical practice. 3. Not primarily for the convenience of the Beneficiary, Beneficiary's family, caretaker, or any provider. 4. The most appropriate supply or level of service which can safely be provided.
Emergency Services and Care	Medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a physician and surgeon, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility. It also means an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary

	to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility.
Expedited Requests	An Expedited Request occurs when the standard process could jeopardize the Beneficiary's life, health, or ability to attain, maintain, or regain maximum functioning. If the Beneficiary or Provider expedited hearing request is approved, a decision will be issued within three (3) working days of the date of the request. Expedited Requests may include Grievances, Appeals and State Fair Hearings. Expedited Requests must be resolved within seventy-two (72) hours of receipt of the request.
Federal Financial Participation (FFP)	Federal revenue claimed by the Plan for the federal share of the reimbursement for service delivered to Medi-Cal beneficiaries.
Fee for Service Medi-Cal (FFSMC)	California's Medi-Cal program provides reimbursement on a per procedure basis for a broad array of health and limited mental health services provided to individuals who are eligible for Medi-Cal. FFS is a payment model where services are unbundled and paid for separately. In health care, it gives an incentive for physicians to provide more treatments because payment is dependent on the quantity of care, rather than quality of care.
Fee for Service/Medi-Cal Hospital	A hospital that submits reimbursement claims for Medi-Cal psychiatric inpatient hospital services through the fiscal intermediary.
Fiscal Intermediary	The Fiscal Intermediary processes reimbursements for Medi-Cal fee for service hospital claims.
Grievance	An expression of dissatisfaction about any matter other than adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Beneficiary's rights regardless of whether remedial action is requested. Grievance includes a Beneficiary's right to dispute an extension of time proposed by BHSD to make an

	authorization decision. There is no distinction between an informal and formal Grievance.
HealthCare Common Procedural Coding System (HCPCS)	A Center for Medicare and Medicaid Services (CMS) uniform coding system consisting of descriptive terms and codes used primarily to identify procedure, supply and durable medical equipment codes furnished by physicians and other health care professionals.
Hospital Liaison	A BHSD employee who is responsible for inpatient hospital contract oversight and patient placements.
Information Necessary to Determine Payer Liability	The minimum amount of material information in the possession of third parties related to a provider's billed services that is required by a claim's adjudicator or other individuals with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the plan's or the plan's capitated provider's liability, if any, and to comply with any governmental information requirements.
Institution for Mental Diseases	A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental disorders, including medical attention, nursing care, and related services.
International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM)	A medical classification list by the World Health Organization (WHO) used by physicians and other healthcare providers to classify and code all diagnoses, symptoms and procedures recorded in conjunction with hospital care in the United States. Maintained by the National Center for Health Statistics, Centers for Disease Control (CDC) within the Department of Health and Human Services (HHS).
LPS Designated Facility	A facility designated by the County and approved by the State DHCS as a Facility for 72-hour Treatment and Evaluation.
Lockouts for Psychiatric Inpatient Hospital Services.	Services that are not reimbursable on days when psychiatric inpatient hospital services are reimbursed, except for the day of admission to psychiatric inpatient hospital services. This includes: (1) Adult Residential Treatment Services, (2) Crisis Residential Treatment Services, (3) Crisis Intervention, (4) STRTP

	(5) Psychiatric Nursing Facility Services, except as provided in Subsection (b), (6) Crisis Stabilization, and (7) Psychiatric Health Facility Services.
Medi-Cal	The name of California's Medicaid program which provides health coverage to people with low-income, the aged, disabled and those with asset levels who meet certain eligibility requirements.
Medical Determination	The medical services that are determined by a qualified licensed practitioner as: 1. Appropriate and necessary for the symptoms, diagnosis, or treatment of medical condition. 2. Within recognized standards of medical practice. 3. Not primarily for the convenience of the Beneficiary, Beneficiary's family, caretaker, or any provider. 4. The most appropriate supply or level of service which can safely be provided.
Medical Necessity	The criteria that identify service needs based on inclusion of specific signs, symptoms, and conditions and proposed treatment associated with behavioral health. Determination of Medical Necessity requires inclusion of a Covered Diagnosis; an established level of impairment; an expectation that behavioral health treatment is necessary to address the condition; and the condition would not be responsive to physical health care-based treatment as cited.
Non-Contract Hospital	A hospital which is certified by the State DHCS to provide Medi-Cal services, but which does not have a contract with a specific MHP to provide psychiatric inpatient hospital services to Beneficiaries.
Notice of Adverse Benefit Determination (NOABD)	Informs the Beneficiary of a denial or change to their SMHS or DMC-ODS services. It also notifies the Beneficiary of the right to request an appeal if the Beneficiary does not agree with BHSD's decision. The NOABD outlines the delays in resolving grievances, appeals, providing services in a timely manner, delays in authorization, or to dispute financial liability.
Non-Reimbursable Psychiatric Inpatient Hospital Services	(a) The MHP may claim FFP for psychiatric inpatient hospital services in a psychiatric health facility that is larger than 16 beds and is certified by the State Department of Health Services as a Medi-Cal provider of inpatient hospital services or an acute psychiatric hospital that is larger than 16 beds only under the following conditions: 1. The beneficiary is 65 years of age or older, or 2. The beneficiary is under 21 years of age, or

	3. The beneficiary was receiving such services prior to his/her twenty-first birthday and the services are rendered without interruption until no longer required or his/her twenty-second birthday, whichever is earlier. (b) The restrictions in Subsection (a) regarding claiming FFP for services in acute psychiatric hospitals and psychiatric health Inpatient Psychiatric Facilities shall cease to have effect if federal law changes or a federal waiver is obtained, and reimbursement is subsequently approved (c) The MHP may not claim FFP for psychiatric inpatient hospital services until the beneficiary has met the beneficiary's share of cost obligations under 22 CCR §§ 50657 - 50659.
Plan	BHSD Medi-Cal managed care plans include the Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS).
Per Diem Rate	A daily rate paid for reimbursable psychiatric inpatient hospital services for a beneficiary for the day of admission and each day that services are provided excluding the day of discharge.
Point of Authorization	The person or persons the Plan designates to intake, adjudicate, and communicate payment authorization determinations for Mental Health Stay in Hospital Treatment Authorization Requests. Point of Authorization conducts eligibility verification and reviews and processes reimbursement for services provided by an acute psychiatric inpatient hospital to a beneficiary is authorized in writing by the Plan.
Post Stabilization Care Services	Covered services, related to an emergency medical condition that are provided after a Beneficiary is stabilized to maintain the stabilized condition, or to improve or resolve the Beneficiary's condition. This can include Beneficiaries: 1) Discharged from the hospital, Emergency Psychiatric Services (EPS), or a crisis residential program. 2) Does not meet 5150 criteria but appears to represent a significant risk to self/others or is gravely disabled. 3) Is at risk for re-hospitalization or 5150. 4) That have poor impulse control. 5) Whose level of functioning significantly impairs their ability to take care of basic needs.

	6) That have a history of EPS admissions, psychiatric hospitalizations, or institutionalization, and is about to run out of medication. Beneficiaries who meet post stabilization criteria must be seen for face to face behavioral health services within five (5) working days of notification.
Prior Authorization	The process of obtaining approval or authorization to perform a covered service in advance of its delivery. Required for Adult Residential, Therapeutic Behavioral Services, Treatment Foster Care and planned psychiatric hospitalization. The Plan will make authorization decisions within five (5) business days of receipt of request.
Prior or Prospective Authorization	- The process of obtaining approval or authorization to perform a covered service in advance of its delivery, such as outpatient ECT
Provider Dispute	A contracted or non-contracted provider's written notice to Plan challenging, appealing, or requesting reconsideration of a claim that has been denied, underpaid, adjusted, contested, or seeking resolution of a billing determination, contract dispute, or disputing a request for reimbursement of an overpayment of a claim.
Psychiatric Emergency Medical Condition	A mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following: A. An immediate danger to himself or herself or to others. B. Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.
Psychiatric Health Facility	A facility licensed by the Department under the provisions of 22 CCR §§77001 - 77155. Psychiatric health Inpatient Psychiatric Facilities that have been certified by the State Department of Health Services as Medi-Cal providers of inpatient hospital services will be governed by the provisions applicable to hospitals and psychiatric inpatient hospital services, except when specifically indicated in context.

Psychiatric Inpatient Hospital Professional Services	Specialty mental health services provided to a beneficiary by a licensed mental health professional with hospital admitting privileges while the beneficiary is in a hospital receiving psychiatric inpatient hospital services. Psychiatric inpatient hospital professional services do not include all specialty mental health services that may be provided in an inpatient setting. Psychiatric inpatient hospital professional services include only those services provided for the purpose of evaluating and managing the mental disorder that resulted in the need for psychiatric inpatient hospital services. Psychiatric inpatient hospital professional services do not include routine hospital services or hospital-based ancillary services.
Quality of Care Concern	Any event or condition that has had or may have an adverse effect on the health or safety of our program Beneficiaries, guests, Workforce Members, or members of the general public. Quality of care concerns include unusual occurrences, unusual incidents, or sentinel events. Examples of quality of care concerns include, but are not limited to, situations involving injury, accident, acute medical problem, aggression/violence, suicide attempt, unauthorized absences, death, inappropriate treatment, unprofessional conduct, loss of medical record, medication issue, facility damage/service disruption, mandated reporting, or any incident that might receive public attention.
Representative	A person who is authorized by the Beneficiary to act on behalf of or assisting a Beneficiary, and may include, but is not limited to, a family member, a friend, a BHSD or provider employee, or a person legally identified as Power of Attorney for Health Care/Advanced Directive, Conservator, Guardian, etc.
Resolution	Means the Grievance or Appeal has reached a final disposition with respect to the Beneficiary's submitted Grievance or Appeal. BHSD Grievance will send the Notification of Grievance Resolution (NGR) to notify Beneficiaries of the results of the Grievance Resolution. The NGR shall contain a clear and concise explanation of the Plan's decision.
Retrospective Authorization	Authorization to deliver a covered service that is granted after it has been rendered.

Retrospective Review	The process of determining coverage after treatment has been given.
Short-Doyle/Medi-Cal Hospital	A hospital that submits claims for Medi-Cal psychiatric inpatient hospital services through BHSD to the state Department of Health Care Services (DHCS) and not to the fiscal intermediary.
Treatment Authorization Request (TAR)	The DHCS form needed to approve funding for inpatient treatment.
Waiver (5751.7)	A request to waive the standard requirement that minors cannot be admitted into a psychiatric treatment facility with adults. A waiver request may be considered if a health facility has treatment staff and treatment programs designed to serve children or adolescents, and there are inadequate or unavailable alternative placements for the minors. In order to obtain a waiver, facilities must be designated to provide civil commitment of minors, have treatment protocols and administrative procedures to identify, and provide appropriate treatment to minors admitted with adults. To obtain a waiver, the facility will follow the LPS Facility Designation Policy and Process Manual.

APPENDIX 4: Mental Health Websites

The following websites can be accessed for additional information:

Disability Rights California:
http://www.disabilityrightsca.org/

Medi-Cal Website:
www.medi-cal.ca.gov

National Alliance of Mentally Ill:
www.nami.org

Santa Clara County Behavioral Health Services Department:
https://www.sccgov.org/sites/mhd/Pages/default.aspx

State of California Department of Managed Health Care:
www.dmhc.ca.gov

State of California Department of Health Care Services:
www.dhcs.ca.gov

State of California Office of Patient Advocate:
www.opa.ca.gov

APPENDIX 5: Reporting Regulations, Requirements and Forms

A. Welfare and Institutions Code § 5402

a) The State Department of Health Care Services shall collect and publish annually quantitative information concerning the operation of this division including the number of persons admitted for 72-hour evaluation and treatment, 14-day and 30-day periods of intensive treatment, and 180-day post-certification intensive treatment, the number of persons transferred to mental health Inpatient Psychiatric Facilities pursuant to § 4011.6 of the Penal Code, the number of persons for whom temporary conservatorships are established, and the number of persons for whom conservatorships are established in each county.
b) Each local mental health director, and each facility providing services to persons pursuant to this division, shall provide the department, upon its request, with any information, records, and reports which the department deems necessary for the purposes of this section. The department shall not have access to any patient name identifiers.
c) Information published pursuant to this section shall not contain patient name identifiers and shall contain statistical data only.
d) The department shall make the reports available to medical, legal, and other professional groups involved in the implementation of this division.

B. Involuntary Detention Reports

To meet existing mandates of WIC § 5402 we ask your facility to complete and send quarterly involuntary detention reports to the county that summarizes the number and type of involuntary detentions at your facility during the prior quarter. BHSD requires LPS Designated Inpatient Psychiatric Facilities and other Inpatient Psychiatric Facilities that serve involuntary patients within Santa Clara County, to compile and submit a quarterly report on Involuntary Detentions using DHCS Form 1010 to BHSD by the 5th day of the month following the end of the prior quarter (i.e., on October 5, January 5, April 5, and July 5). Include a de-identified summary of any associated grievance, incident, or adverse event reports.

The state form is located at:

http://www.dhcs.ca.gov/formsandpubs/forms/Pages/Mental_Health-Forms.aspx

Note that DHCS requires LPS Designated Inpatient Psychiatric Facilities to report on those individuals who are treated involuntarily in private psychiatric Inpatient Psychiatric Facilities, those whose treatment is funded by private resources, and those whose treatment is funded through Medi-Cal or the County's Behavioral Health Program.

BHSD may also request a record review at any time to determine if involuntary patient advisement, patient notifications and other related materials have been reviewed and are contained in the medical record.

C. Convulsive Treatment

If your facility provides convulsive treatment, you must submit DHCS Form 1011 to BHSD by the 5th day of the month following the end of the prior quarter (i.e., on October 5, January 5, April 5, and July 5). Include a de-identified summary of any associated grievance, incident, or adverse event reports.

The state form is located at:

http://www.dhcs.ca.gov/formsandpubs/forms/Forms/Mental_Health/DHCS-1011.pdf

BHSD may also request a record review at any time to determine if the patient completed informed consent for convulsive treatment.

D. Patient Denial of Rights

The facility is responsible for maintaining records of patients' rights denial. This includes a monthly tally sheet in the patient's treatment record and submission of a monthly facility incidents of Denial of Rights/Restraint and Seclusion. Submit DHCS Form 1804 to both BHSD and the Mental Health Advocacy Project (MHAP) by the 5th day of the following month (i.e., on August 5, September 5, October 5…). Include a de-identified summary of any associated grievance, incident, or adverse event reports.

Reports should be sent to:

Director, Behavioral Health Services Department
LPS Facility Reports
828 S. Bascom Ave, Suite 200
San Jose, CA 95128
FAX (408)885-5789

E. Incident Report

Attached next page.

CONTRACT AGENCY BEHAVIORAL HEALTH SERVICES DEPARTMENT

INCIDENT REPORT
CONFIDENTIAL REPORT OF INCIDENT (NOT PART OF THE MEDICAL RECORD)
ATTORNEY-CLIENT PRIVILEGED COMMUNICATION

Name of Consumer or person Involved: ____________________ Date of Report: __________

Remedial actions taken/planned by program (include dates/estimated dates of completion for each step/action):

Witnesses or Persons Familiar with Incident:

Name: ____________________ Phone#: __________

Address: ____________________
Street *City* *State, Zip Code*

Staff Person / Witness:		**Agency Director/Designee:**	
Name:		Name:	
Phone#:		Phone#:	
Date:		Date:	
Signature:		Signature:	

For Use by Behavioral Health Services Department Only

Division Director/Designee: ____________________ Date: __________

Behavioral Health Services Department Follow Up:

BHSD Administrative Signatures:

BHSD Director/Deputy:		Date:
BHSD Medical Director/Designee:		Date:
BHSD Division Director:		Date:
BHSD Quality Improvement Manager:		Date:

2 of 2 ***Double Sided*** SCCBHSD -Revised: 9/20/17

F. State Reports

See next pages or find at

https://www.dhcs.ca.gov/formsandpubs/forms/Pages/Mental_Health-Forms.aspx

QUARTERLY REPORT ON INVOLUNTARY DETENTIONS

County Name:

County Code:

			Year
Quarter 1	☐	July 1 to Sept. 30	____
Quarter 2	☐	Oct. 1 to Dec. 31	____
Quarter 3	☐	Jan. 1 to March 31	____
Quarter 4	☐	April 1 to June 30	____

SUMMARY OF INVOLUNTARY DETENTIONS IN COUNTY DESIGNATED FACILITIES
(excluding State Hospitals)

Provider Code	Facility Name	72-Hr. Eval & Treatment		14-Day Intensive Treatment	Additional 14-Day Intens. Treat (Suicidal)	30-Day Intensive Treatment	180-Day Post Certification
		Child/Adol (0-17 Yrs)	Adult (18 & Up)				

The above information is required by the California Welfare and Institutions Code (WIC) Section 5402(a).
The information provided in this quarterly report will be incorporated into an annual report as required by WIC Section 5402(d). ***Please see the next page or reverse side for Reporting Instructions***. **This quarterly report should be submitted by the 30th of the month following the end of each quarter via email, fax, or U.S. Mail.** If you need assistance preparing this report, please send an email to one of the persons below.

Fax Number: **(916) 440-7621**

Email Address: MHSDATA@dhcs.ca.gov

Mailing Address: **DEPARTMENT OF HEALTH CARE SERVICES**
Mental Health Analytics Section, MS2704
P.O. BOX 997413
SACRAMENTO, CA 95899-7413

DATE	CONTACT PERSON	PHONE NUMBER

DHCS 1010 REPORTING INSTRUCTIONS:

SPECIAL INSTRUCTIONS: This reporting applies to all instances of involuntary treatment regardless of funding source. That is, persons who are treated involuntarily in private psychiatric Inpatient Psychiatric Facilities or whose treatment is funded by private resources must be reported along with persons whose treatment is funded through Medi-Cal or the county mental health program. **Do not count persons who are referred to another county for services. It is the responsibility of the county in which a treatment facility is located to include all of the information about the facility in its report.**

If there are no designated Inpatient Psychiatric Facilities, public or private, within your county in which at least one person was admitted involuntarily for evaluation and treatment, you must still submit this report on a quarterly basis with zero counts in each of the boxes provided. For example: In the "Facility Name" box enter "NO FACILITY", and zero fill each of the six treatment categories.

For each private or public facility reported, completely fill out each category of Involuntary Detention. Do not leave any section blank. If there are no counts for a specific category, please enter a zero count. Please include a telephone number of the county contact for data verification purposes.

Please use one form to report each quarter.

PROVIDER CODE: Enter the provider code for the facility assigned for the Cost Reporting System. If the facility is not a Short-Doyle provider, then leave blank.

FACILITY NAME: Enter the names of all Inpatient Psychiatric Facilities, public or private, designated by the county to which at least one person was admitted involuntarily for 72-hour evaluation and treatment, 14-day intensive treatment, Additional 14-day intensive treatment (Suicidal), 30-day intensive treatment, or 180-day post certification during the reporting period. **Exclude State Hospitals for the Mentally Disabled from the list of designated Inpatient Psychiatric Facilities.** These are being reported by the State Hospitals.

Note: A person who initially is admitted to a unit within a facility and is subsequently transferred to another unit within the same facility or to another facility for the same treatment episode while being held under the same Welfare & Institutions (WIC) section is to be counted only once. This person is to be counted in the unit or facility where each specific detention was initiated. This is to eliminate duplicate reporting.

72-HOUR EVALUATION AND TREATMENT: Enter the total count of persons admitted to the county designated facility for 72-hour treatment and evaluation under WIC §§ 5150, 5170, 5200, 5225, and 5585.55 during the report quarter. If the same person was admitted more than once during the quarter for 72-hour evaluation and treatment, count each admission. The number of persons reported should be separated into two groups, children, and adolescents (0-17 years old) in one and adults (18 years & over) in the other as indicated.

14-DAY INTENSIVE TREATMENT: Enter the total count of persons certified during the report quarter for 14 day intensive treatment under WIC § 5250. ADDITIONAL 14-DAY

INTENSIVE TREATMENT (SUICIDAL): Enter the total count of persons certified during the report quarter for an additional 14-days intensive treatment due to suicidal tendencies under WIC § 5260. If the same person is involuntarily detained for a 14-day certification more than once during the quarter, count each certification.

30-DAY INTENSIVE TREATMENT: Enter the total count of persons certified during the report quarter for an additional period of intensive treatment of not more than 30 days under WIC §5270.15 for gravely disabled mentally disordered individuals who are unable to sufficiently stabilize within the 14-day period of intensive treatment.

180-DAY POST-CERTIFICATION: Enter the total count of persons certified during the report quarter for 180 days additional treatment under WIC §§ 5303 and 5304.

State of California - Health and Human Services Agency

Department of Health Care Services

DENIAL OF RIGHTS/SECLUSION AND RESTRAINT MONTHLY REPORT

(See Instructions on Reverse Side)

Month:

Year:

Facility: Program/Ward: County:

Name, Title and Telephone Number Of Person Preparing Report:

Date of Report:

A	B	C Number of Days Denied Each Right or Days in Seclusion/Restraint									
Patient's I.D.	No. of Days In Facility	1	2	3	4	5	6	7	8	9	10
D Total No. of Patients in 1-10											

ONLY THE FOLLOWING RIGHTS MAY BE DENIED FOR GOOD CAUSE:

1. Right to wear one's own personal possessions WIC 5325 (a)
2. Right to keep & use one's own personal possessions WIC 5325 (a)
3. Right to keep and be allowed to spend a reasonable sum of one's own money for canteen expenses and small purchases WIC 5325
4. Right to have access to individual storage space for one's private use WIC 5325 (c)
5. Right to see visitors each day WIC 5325 (d)
6. Right to have reasonable access to telephones, both to make and receive confidential calls or to have such calls made for them WIC 5325 (d)
7. Right to have ready access to letter writing materials, including stamps WIC 5325 (e)
8. Right to mail and receive unopened correspondence WIC 5325 (f)

RESTRICTIONS IMPOSED

9. Seclusions (isolation of an involuntary patient in a locked room)
10. Restraints (any physical device used to immobilize the patient because of behavioral problems.)

Instructions for DHCS Form 1804

COLUMN A: Patient's I.D. or Hospital Number

Each patient who has been denied a right or placed in seclusion/restrain by the facility during the reporting month must be listed on this form by I.D. or hospital number.

COLUMN B: Number of Days in Facility this Month

Enter each patient's total days in the facility for the month.

COLUMN C: Number of Days Denied Each Right or Days in Seclusion/Restraint

Enter in Columns 1 through 10 the number of days each patient was denied a right or in seclusion/restraint.

COLUMN D: Totals-Numbers of Patients Denied Each Right

Enter in Column D, the total number of patients denied each right or placed in seclusion/restraints. (Do not count the numbers in the boxes to achieve Column D as the number of patients, not days, is needed.)

RESTRICTIONS IMPOSED

Seclusion and restraints MUST be reported and documented because these actions imply the denial of other specific patients' rights, such as the right of access to the telephone.

These implied denials need not be documented in the patient's chart and should not be reported on this form.

When the exercise of a particular right is specifically requested by the patient, however, and denied by the staff while the patient is in restraint or seclusion, the denial of that right MUST be documented in the patient's record and reported on this form.

SUBMIT TO: Mental Health Advocacy Project (MHAP) by the 10th of the following month.

MHAP will compile a quarterly aggregate report to submit to the Local Mental Health Director and to appropriate State offices.

Mental Health Advocacy Project
152 North 3rd Street, 3rd Floor
San Jose, CA 95112
FAX: (408) 350-1158

State of California - Health and Human Services Agency | Department of Health Care Services

CONVULSIVE TREATMENTS ADMINISTERED – QUARTERLY REPORT

County	Reporting Facility or Doctor		Report Date
For Quarter Ending	Number of Patients Treated By Major Source of Payment	Private:	3rd Party Payer:
		Public:	Other:

SECTION I — NUMBER OF PATIENTS RECEIVING TREATMENT

PATIENT DISTRIBUTION / PATIENT TYPE	AGE								SEX			RACE							
	12 - 15	16 - 17	18 - 24	25 - 44	45 - 64	65+	Unknown	Total	Male	Female	Total	White	Black	Hispanic	Asian	Amer. Indian	Filipino	Other	Total
Voluntary Patient - With Informed Consent								0			0								0
Voluntary Patient - Not capable of Informed Consent								0			0								0
Involuntary Patient - With Informed Consent								0			0								0
Involuntary Patient - Not Capable of Informed Consent								0			0								0
TOTALS	0	0	0	0	0	0	0		0	0		0	0	0	0	0	0	0	

SECTION II — TOTAL TREATMENTS GIVEN

	12 - 15	16 - 17	18 - 24	25 - 44	45 - 64	65+	Unknown	Total	Male	Female	Total	White	Black	Hispanic	Asian	Amer. Indian	Filipino	Other	Total
Convulsive Treatments								0			0								0

SECTION III — COMPLICATIONS ATTRIBUTABLE TO TREATMENT

	12 - 15	16 - 17	18 - 24	25 - 44	45 - 64	65+	Unknown	Total	Male	Female	Total	White	Black	Hispanic	Asian	Amer. Indian	Filipino	Other	Total
Cardiac Arrest - Nonfatal								0			0								0
Memory Loss - reported								0			0								0
Fractures								0			0								0
Apnea								0			0								0
Death - No Coroner Report								0			0								0
Death - With Coroner Report								0			0								0
TOTALS	0	0	0	0	0	0	0		0	0		0	0	0	0	0	0	0	

SECTION IV — EXCESSIVE TREATMENTS

	12 - 15	16 - 17	18 - 24	25 - 44	45 - 64	65+	Unknown	Total	Male	Female	Total	White	Black	Hispanic	Asian	Amer. Indian	Filipino	Other	Total
Patients - Excessive Treatments								0			0								0

PREPARED BY:

TELEPHONE NUMBER (including area code):

SUBMIT TO:

County Mental Health Director

DO NOT MODIFY THIS FORM FOR SUBMITTAL TO THE DEPARTMENT OF HEALTH CARE SERVICES

REPORTING INSTRUCTIONS:

1. Complete All Heading Items

Note: Under "Number of Patients Treated by Major Source of Payment", enter the number of patients given Convulsive Therapy Treatments according to their Major Source of Payment for Treatment. Categorize Source of Payment into one of the following types: (a) Private, (b) Public (including but not limited to Medicare, Medi-Cal, and Short-Doyle), (c) Third Party Payor, (d) Other (Specify).

2. SECTION I "NUMBER OF PATIENTS RECEIVING TREATMENT"

   A. For each Patient Type (i.e., Voluntary Patient – With Informed Consent, Voluntary Patient – Not Capable of Informed consent, *Involuntary Patient – With Informed consent, and *Involuntary Patient – Not capable of Informed Consent) indicate the number of patients receiving treatment during the report quarter by age group, sex, and race. The PDF form will automatically total the columns and rows. **(If totals do not match, verify data posting.)**

   Involuntary patients include patients under guardianship or conservatorship

3. SECTION II "TOTAL TREATMENTS GIVEN"

   A. Enter the total number of treatments given during the report quarter for all Patient Types by age group, sex, and race. The Excel spread sheet will automatically total the row. **(If totals do not match, verify data posting.)**

4. SECTION III "COMPLICATIONS ATTRIBUTABLE TO TREATMENT"

   A. For each type of complication, enter the number of complications attributable to Convulsive Therapy Treatments that occurred by age group, sex, and race of the patient. The PDF form will automatically total the columns and rows. (If totals do not match, verify data posting.)
   B. Complications to be reported:
      a. non-fatal cardiac arrests or arrhythmias which required resuscitative efforts.
      b. memory loss reported by the patient extending more than 3 months following the completion of the course of treatment (when reporting memory loss subsequent to a course of treatment which was reported on a previous quarterly report, designate separately with an asterisk).
      c. fractures, with a medical diagnosis of the fracture accompanying quarterly.
      d. apnea persisting 20 minutes or more after initiation of treatment.
   e. deaths which 1) occur during or within first 24 hours after a treatment; or 2) occur subsequently but are attributable to the treatment. All deaths in the first category shall be reported to the coroner and the coroner's report shall accompany the quarterly report. In all cases in which an autopsy is performed,

the autopsy report shall also accompany the quarterly report. The required accompanying reports in c) and e) above shall observe the confidentiality requirements of WIC §5328 5. SECTION IV "EXCESSIVE TREATMENT"

A) Indicate the number of patients by age group, sex, and race who receive more than 15 treatments within a 30-day period during the quarter or who received more than 30 treatments within the immediately preceding one year. Attach documentation of the prior approval. The PDF form will automatically total the row. **(If totals do not match, verify data posting.)**

6. **REPORTS must be submitted to the County Mental Health Director as indicated in the lower right corner on the front of this form by the 15th of the month following the completion of the quarter.**

7. THE COUNTY MENTAL HEALTH DIRECTOR shall transmit the accumulated quarterly reports, by the last day of the month following the end of the quarter, to:

Department of Health Care Services
Mental Health Analytics Section, MS2704
P.O. Box 997413
Sacramento, CA 95899-7413

NOTE: WIC § 5326.9 addresses violations of the laws governing the denials of rights.

If you need assistance preparing this report, please send an email to: MHSDATA@dhcs.ca.gov

DO NOT MODIFY THIS FORM FOR SUBMITTAL TO THE DEPARTMENT OF HEALTH CARE SERVICES.

CONTRACT AGENCY BEHAVIORAL HEALTH SERVICES DEPARTMENT

INCIDENT REPORT

CONFIDENTIAL REPORT OF INCIDENT (NOT PART OF THE MEDICAL RECORD)

ATTORNEY-CLIENT PRIVILEGED COMMUNICATION

To: Quality Assurance Program
Santa Clara County Behavioral Health Services Department
828 S. Bascom Ave, #200, San Jose, CA 95128 Fax: 408-288-6113

BHSD P&P 412-122 (ATTACHMENT 1)
Contract Agencies

Identify Division: ☐ Adult ☐ Family & Children ☐ Criminal Justice ☐ Housing ☐ Integrated Bx Health Services

Program Name: ______ Date of Report: ______

Name of consumer or person involved: ______ (*Last* / *First* / *Middle*) Unicare#: ______

Sex: ☐ Male ☐ Female Age: ______ Diagnosis: ______

Primary BHSD Provider: ______ (*Name & Discipline*) Attending BHSD MD: ______

Account of Incident

Occurred: ☐ Offsite ☐ Onsite ______ *Location* *Date (MM/DD/YY)* *Time (HH:MM)*

Check all that apply:

☐ Assaulted by Peer/Other ☐ Assaulted Peer/Staff ☐ AWOL ☐ EPS/CSU Visit
☐ ER Visit ☐ Fell ☐ HIPAA Violation
☐ Homicidal Ideation ☐ Medical Issue ☐ Medication Issue ☐ Self-Injury
☐ Sexual Incident ☐ Suicide Attempt ☐ Suicide Ideation
☐ Other *Please specify:(i.e., Fire Alarms, Bed Bugs, Stealing, etc.)* ______

Provide details of incident as related by consumer and/or witness. Include condition of person(s) involved, relevant medication, date last seen in clinic, etc. (Write legibly. Attach additional sheets if needed):

Pertinent Background / History (Include any prior activity to incident, other activity related, or contributing to incident; and how long this consumer has been open to the system):

Severity of Injury to Client/Staff or event (check one):

☐ 1. None: No apparent physical injury or unknown
☐ 2. Minor: Injury or event not requiring treatment
☐ 3. Moderate: Injury or event requiring treatment
☐ 4. Major: Serious and/or life threatening injury or event
☐ 5. Death

APPENDIX 6: County Resources

This section consists of Children, Youth and Family (CYF) Resources in Section A and Adult Older Adult Resources in Section B.

A. Family and Children Resources

Short Term Residential Therapeutic Program (STRTP)

Santa Clara County Behavioral Health Family and Children's Divisions provide STRTP services. The STRTP is an element of therapeutic treatment as outlined in AB 403 Continuum of Care Reform. The STRTP is short term (6 months or less) highly intensive residential treatment for qualifying youth ages 10 to 17 from Probation and Child Welfare systems. The intent of the program(s) is to enable a youth to improve functioning in the areas of education, health, behavioral and transitions into young adulthood.   On October 1, 2021, in compliance with the Families First Preservation Act (FFPSA) all referrals for STRTP treatment requires the evaluation by a Qualified Individual (QI). Referrals and approved by the Interagency Placement Committee (IPC). The services provided are Specialty Mental Health Services (SMHS) and full scope Medi-Cal is a requirement.

County Contacted- Short Term Residential Therapeutic Programs

Chamberlain's Youth Services
1850 San Benito Street
Hollister, CA 95023
(831) 636-2121
Serve children ages 6-18

Fred Finch Youth Center
3800 Coolidge Avenue
Oakland, CA 94602
(510) 482-2244
Serve children ages 12-18
Dually diagnosed Mental Health need and Intellectual/Developmental Disability

CYF Hospital Liaison

The role of the Hospital Liaison is to provide clinical consultation and care coordination between acute inpatient psychiatric teams and behavioral health providers. Provides the following functions:

1. Facilitates and the coordinates patient care with the inpatient hospital Social Service staff to ensure that the inpatient hospital staff have the needed information to provide following functions:

- Collateral Information for bio- psycho-social assessment
- Assess level of care needed for referral to Behavioral Health services
- Collaboration with existing Behavioral Health and child serving agencies/department
- Child or youth's functioning in the milieu
- Ensure that a safety plan to reflect needs that led to the hospitalization
- Reflect on warning signs that lead to the crisis and include them in safety plan
- Coordinate with the family while the child or youth is in the hospital.

2. The Hospital Liaison attends family and/or safety planning meetings and coordinate with outpatient after discharge from the hospital
3. The Hospital Liaison interviews children and youth to gain perspective on their needs for treatment both in hospital and when discharged
4. The Hospital Liaison works collaboratively with Crisis Stabilization Unit and Emergency Psychiatric Services to ensure smooth transition between and out of service when no inpatient hospitalization is required

Children Youth and Families Division Crisis Stabilization Facilities

Uplift Family Services Crisis Stabilization Unit (CSU)
251 Llewellyn Ave.
Campbell, CA 95008
24-HOUR CRISIS LINE (408) 379-9085 or toll-free **(877) 41-CRISIS** (412-7474)

The Crisis Stabilization Unit Provides the following services

- Service Delivery Components
  - LPS Receiving Center for 5150 Assessment and Stabilization
  - Evaluation by Psychiatrist
  - Bio-psychosocial Assessment
  - Crisis Assessment
  - Safety Planning with Caregiver and Youth
  - Referral and Aftercare planning
  - Length of Service: 23 hours and 59 minutes
  - Serves up to 12 children/adolescents up to age 18

County Contracted Inpatient Psychiatric Facilities that Serve Youth

Fremont Hospital
39001 Sundale Drive
Fremont, CA 90438
(510) 574-4811

John Muir
2740 Grant St.
Concord, CA 94520
Phone (925) 674-4100

San Jose Behavioral Health Hospital
455 Silicon Valley Boulevard
San Jose, CA 95138
(877) 801-545

Saint Helena Hospital Center for Behavioral Health
525 Oregon St,
Vallejo, CA 94590
(707) 649-4040

San Jose Behavioral Health Hospital
455 Silicon Valley Boulevard
San Jose, CA 95138
(877) 801-5455
Pre-auth, follow up appointment and placement, school integration program

B. Adult and Older Adult (AOA) Referrals to Long-Term Care Services and Skilled Nursing Inpatient Psychiatric Facilities

24-Hour Care Unit

24 Hour Care monitors and coordinates the day to day admission and discharges of all County and Contracted residential mental health programs. The team authorizes adult and older adult admissions to IMD's, IMD Diversion programs, supplemental care homes and dedicated shelter beds. 24 Hour Care also provides assessment services and acts as a liaison to acute inpatient hospitals. Inpatient Psychiatric Facilities must contact 24 Hour Care to coordinate and obtain authorization to transfer to residential levels of care.

24 Hour Care
24hrcare@hhs.sccgov.org
(408) 885-7580

Title 9, CCR § 541 24-Hour Services

24-Hour Services mean services designed to provide a therapeutic environment of care and treatment within a residential setting for adults and minors. Depending on the severity of the disorder, dangerousness to self or others, and the need for related medical care, treatment is provided through one of the following service functions:

a) State Hospital, or Developmental Center as specified in WIC § 4440.5 of means a health facility licensed pursuant to HSC § 1250 and operated by the Departments of State Hospitals or Developmental Services, as defined in WIC §§7200 and 7500, respectively, and which provides treatment services for mentally disordered and developmentally disabled individuals.
b) Local Hospital, which means an acute psychiatric hospital as defined in HSC §1250 of the Health and Safety Code, or a distinct acute psychiatric part of a general hospital as defined in HSC § 1250 which is approved by the Department of Health Care Services to provide psychiatric services.
c) Psychiatric Health Facility, which means a health facility as defined in HSC § 1250.2, or such facility which has a waiver of licensure from the Department, which provides intensive care.
d) Intensive Skilled Nursing Facility, which means a health facility as defined in HSC § 1250 and staffed to provide intensive psychiatric care.
e) Short-Term-Crisis Residential Service (Less than 14 Days), which means a licensed residential community care facility available for admissions 24-hours a day, 7 days a week, and staffed to provide crisis treatment as an alternative to hospitalization. Admissions are generally limited to a stay of less than 14 days for voluntary patients without medical complications requiring nursing care. Twenty-four hour capability for prescribing and supervising medication must be available for patients requiring this level of care. The prescribing capability shall be provided by written agreement.
f) Short-Term Crisis Residential Service (Less than 30 Days), which means a licensed residential community care facility available for admissions 24-hours a day, 7 days a week, and staffed to provide mental health treatment services for voluntary patients without medical complications requiring nursing care and who generally require an average stay of 14-30 days for crisis resolution or stabilization. Twenty-four hour capability for prescribing and supervising medication must be available. The prescribing capability shall be provided by written agreement. Respite care, in accordance with Welfare and Institutions Code, Chapter 5, up to a maximum of 30 days, may be provided within this definition.
g) Transitional Residential On-Site Service, which means a licensed residential community care facility, designed to provide a comprehensive program of care consisting of a therapeutic residential community plus an all-inclusive structured treatment and rehabilitation program for individuals recovering from an acute stage of illness who are expected to move towards a more independent living situation, or higher level of functioning, within a 3-to-12-month period.
h) Transitional Residential Off-Site Service, which means a licensed residential community care facility, designed to provide, for a 3-to-12-month period, a therapeutic residential community including a range of social rehabilitation activities for individuals who are in remission from an acute stage of illness, and interim support to facilitate movement towards the highest possible level of functioning. Individuals may receive day, outpatient, and other treatment services outside the transitional residence.
i) Long-Term Services, which mean services provided in a variety of community facilities for individuals who require care, supervision, resocialization, rehabilitation, and life-enrichment for up to 3 years. Consistent with individual

level of care needs, services shall be provided in skilled nursing facilities, intermediate care facilities, residential community care facilities, or other similar facilities.

j) Semi-Supervised Living Services, which mean services provided for persons living alone or together in small cooperative housing units, who require support in case of emergencies, as well as regular assessment and evaluation of the problems of daily living. Services may include provision of a rent subsidy. This service provides a transition to independent living or an indefinite arrangement.

k) Independent Living Services, which mean services, including psychological support and rent subsidy, if necessary, provided to persons who require only minimal support to remain in the community.

County Operated Adult Older Adult Inpatient Psychiatric Facilities

Emergency Psychiatric Services (EPS)
871 Enborg Lane
San Jose, CA 95128
(408) 885-6100

Emergency psychiatric Services (EPS) is a locked psychiatric emergency room operated by the Acute Psychiatric Services Division of Valley Medical Center (VMC) and is the only LPS Designated locked psychiatric emergency room in Santa Clara County. EPS provides 72 hour evaluation, crisis stabilization and appropriate referral to involuntary and voluntary patients.

Barbara Aron's Pavilion
Santa Clara Valley Medical Center
820 Enborg Court
San Jose, CA 95128
(408) 885-5000

A County Behavioral Health Services Department operated acute inpatient hospital. Referrals are obtained through EPS.

County Contracted Adult Older Adult Inpatient Psychiatric Facilities

Crestwood Behavioral Health

a. Location: 1425 Fruitdale Avenue, San Jose, CA 95128
b. Phone: 408-275-1010

Fremont Hospital

a. Location: 39001 Sundale Dr., Fremont, CA 94538
b. Phone: 510-596-1100

Good Samaritan Hospital

a. Location: 2425 Samaritan Drive, San Jose, CA 94124
b. Phone: 408-559-2011

John Muir Hospital

a. Location: 2740 Grant Street, Concord, CA 94520
b. 925-674-4100

San Jose Behavioral Health

a. Location 455 Silicon Valley Blvd, San Jose, CA 95138
b. Phone: 669-900-1731

St. Helena Adventist Health

a. Location: 10 Woodland Road, Saint Helena, CA 94574
b. Phone: 707-963-3611

St. Helena Vallejo

a. Location: 525 Oregon Street, Vallejo, CA 94590
b. Phone: 707-648-2200

County Lanterman-Petris-Short Designated Inpatient Psychiatric Facilities for Adults and Older Adults

Barbara Aron's Pavilion
Santa Clara Valley Medical Center
820 Enborg Court
San Jose, CA 95128
(408) 885-5000

Crestwood Psychiatric Health Facility (12 Dedicated Beds)
1415 Fruitdale Avenue
San Jose, CA 95128
(408) 275-1010

El Camino Hospital
2500 Grant Road
Mountain View, CA 94039
(650) 940-7000

Good Samaritan Hospital
2425 Samaritan Drive
San Jose, CA 95124
(408) 559-2011

Kaiser Permanente Psychiatric Health Facility
3840 Homestead Road
Santa Clara, CA 95051
(408) 851-4850

San Jose Behavioral Health Hospital
*Medi-Cal only ages 18-22 and 65+
455 Silicon Valley Boulevard
San Jose, CA 95138
(877) 801-5455

Stanford Hospital
300 Pasteur Drive
Stanford, CA 94304
(650) 723-4000

Veterans Administration Hospital*
3801 Miranda Avenue
Palo Alto, CA 94304
(800) 999-5021

*Veterans Only

Adult Older Adult Residential Inpatient Psychiatric Facilities

BHSD contracts with psychiatric facilities and mental health rehabilitation centers also known as IMDs (Institute for Mental Disease) and Skilled Nursing Facilities (SNFs) to provide psychiatric and medical care to the most vulnerable and high need clients in the BHSD system. The BHSD also has contracts with the state hospitals and other psychiatric facilities outside of Santa Clara County.

General Admission Criteria:

- Client must have a primary psychiatric diagnosis that meets medical necessity
- Client has suicidal or homicidal ideation with active plans and intent at the time of assessment
- Actively psychotic and psychotic symptoms must interfere with daily functioning
- Refusing medications while actively psychotic in an acute setting
- Client must be over 18 years of age
- Client must be Santa Clara county resident

- Client is gravely disabled and unable to make a plan for self-care
- Unmanageable behaviors, such as hitting, kicking, PICA, spitting, spreading feces, sexually in appropriate behaviors, disrobing, violence, aggression, non-medication compliance, etc.
- Unable to perform ADLs independently

Skilled Nursing Inpatient Psychiatric Facilities with Special Treatment Program Institutes for Mental Disease (SNF/IMD/M)) Adult Older Adult County Contracted

These Inpatient Psychiatric Facilities provide 24-hour/day skilled nursing care and supervision to patients with a primary psychiatric diagnosis, who may also have co-existing medical conditions. These Inpatient Psychiatric Facilities offer programs for adults as well as Geri-Psych programs for patients 65 years of age and older. In most cases, patients are Conserved under Lanterman-Petris-Short Act (LPS) and followed by Service Teams. Admission is by approval of the BHSD 24 Hour Care Unit.

7th Avenue Center (IMD)

a. Location: 1171 7th Avenue, Santa Cruz, CA 95062
b. Phone: 831-476-1700

Crestwood Behavioral Health

a. Locations:
    i. Crestwood Treatment Center (SNF), 2171 Mowry, Fremont, CA 94538 Phone: 510-793-8383
    ii. Crestwood Manor (SNF), 4303 Stevenson Blvd, Fremont, CA 94538 Phone: 510-651-1244
    iii. Crestwood Manor (SNF), 1400 Celeste Drive, Modesto, CA 95355 Phone: 209-526-8050
    iv. Crestwood Manor (SNF), 1130 Monaco Court, Stockton, CA 95207 Phone: 209-478-2060
    v. Crestwood (SNF/IMD), Redding 3062 Churn Creek Rd, Redding, CA 96002 Phone: (530) 221-0976
    vi. Crestwood Manor (SNF), Sacramento 2600 Stockton Boulevard Sacramento, CA 95817 (916) 452-1431
    vii. Crestwood (MHRC), Vallejo 115 Oddstad Drive Vallejo, CA 94589 Phone: (707) 552-0215
    viii. Crestwood (MHRC), Lompoc 303 S. C Street Lompoc, CA 93436 Phone: (805) 308-8720
    ix. Crestwood (PHF), 1425 Fruitdale Avenue, San Jose, CA 95128 Phone: 408-275-1010

Dycora Transitional Health-San Jose (IMD)

a. Location: 401 Ridge Vista Avenue, San Jose, CA 95127
b. Phone: Phone: 408-923-7232

Helios-Idylwood Care Center (SNF)

a. Location: 1002 W. Fremont Avenue, Sunnyvale, CA 94087
b. Phone: 408-793-2382

Medical Hill (SNF)

a. Location: 475 29th. Street, Oakland, CA 94609
b. Phone: 510-832-3222

Silicon Valley Post-Acute (SNF)

a. Location: 2295 Plummer Avenue, San Jose, CA 95125
b. Phone: (408) 269-0701

Telecare dba Garfield Neurobehavioral Center (SNF)

a. Location: 1451 28th Avenue, Oakland, CA 94601
b. Phone: 510-262-9191

SANTA CLARA COUNTY MENTAL HEALTH PLAN
MEDI-CAL INPATIENT CONSOLIDATION

SMHS Request for Payment Authorization

SANTA CLARA COUNTY Behavioral Health Services

This admission must meet the following criteria in order to qualify for payment:
a) An EMERGENCY ADMISSION and b) A valid Santa Clara County Medi-Cal beneficiary or
c) A Pre-approved and qualified Santa Clara County Short-Doyle/Indigent patient

LOG#

CONFIDENTIAL PATIENT INFORMATION -See California Welfare and Institutions Code Section 5328

PATIENT ADMISSION INFORMATION

☐ **Prior Authorization** - Prior Authorization is needed for Adult Residential, DTI, Day Rehab, TBS, TFC or Planned hospitalization. Prior Authorization must be requested at least 5 days in advance.

☐ **Concurrent Authorization** - Concurrent Authorization is required for Crisis Residential Treatment Services, PHF an PIHS. Concurrent Authorization is requested on first day of admit and conducted through discharge.

☐ **Expedited Authorization** - Expedited Authorization is a request for a 72 hour decision for authorization due to standard decision time frames.

Name of Patient: DOB: Gender: M F
Date of Admit: Time: Legal Status: Employed: Y N
DSM V Dx: Admitting Physician:
Referred From: Living Situation:

PRIMARY COVERAGE INFORMATION

☐ Medi-Cal[1] ☐ Medicare ☐ Private Insurance[2] ☐ HF/HK[3] ☐ County Funded[4]

[1] EVC#: [2] Carrier Name: [4] Funding Approved by:

SSN: Medi-Cal BIC ID: [2/3] Policy #:

Comments:

All Treatment Authorization Requests are subject to utilization review and approval by MHP prior to payment.

TREATMENT FACILITY INFORMATION

Admitting Facility: Phone:
Staff Reporting: Date: Time:
Santa Clara County (Co. 43) EPS Staff Approving Adult Treatment:

Title 9 regulations require that all inpatient admissions for Medi-Cal recipients eligible for primary, secondary or Short-Doyle funding be reported to the responsible county. In advance, for prior authorization and on the first day of admission, for concurrent review. Please notify Santa Clara County by reporting to:

CO. 43 MHP/UR DEPT BY PHONE: 1-888-728-4264 OR 1-408-885-4867 &/OR FAX FORM TO: 1-408-279-0806

DISCHARGE INFORMATION/ CODING

Date of Discharge: Time: Legal Status:
DSM V Dx:
Transported by: (Ambulance, cab, case mgr, family, etc.) Living Situation: (Self, family, friends, group home, IMD, etc.)
Referral(s): (Outpatient clinic/services, support organization, follow-up mental health treatment, etc.)

PLEASE FAX OR MAIL COMPLETED REQUEST FOR PAYMENT AUTHORIZATION AND CHART TO:

COUNTY of SANTA CLARA, ICMC/UR Department

828 S. Bascom Ave., Ste. 200, San Jose, CA 95128-2600

(Jan. 2018)

APPENDIX 8: Expedited Appeal

SANTA CLARA COUNTY BEHAVIORAL HEALTH SERVICES DEPARTMENT
GRIEVANCE AND APPEAL FORM

If you have any problems with your mental health services, you may contact a **Quality Improvement Coordinator at 1-800-704-0900** or mail this form to the Quality Improvement Program, P.O. Box 28504, San Jose, CA 95159-8504. Prepaid and pre-addressed envelopes are available.
You can also contact the **Mental Health Advocacy Project at 1-800-248-MHAP or (408) 294-9730** for additional assistance.

Grievance ☐ **Appeal** ☐ **Expedited Appeal** ☐

Please Print or Write Clearly Insurance Type: ______________________________

Name:____Date of Birth:______________

Social Security Number:____________________________Phone: _______________________

Address:_____________________________________City:___________State:_____Zip:_____

Name of Legal Guardian/Conservator:____

Name of Agency/Staff Person Providing Service: ______________________________________

1. Describe the problem or issue: (Attach additional sheets if necessary.)

2. What have you already done to resolve this problem?

3. How would you like to see this problem resolved?

Client Signature ______________________________ Date: _______________

Revised January 28, 2016

APPENDIX 9: ECT Request Form

Santa Clara Valley Health & Hospital System
Behavioral Health Services
Electroconvulsive Therapy (ECT) Request Form

Date: ______________

Hospital Where ECT Will Be Provided: ____

Address: ____

Telephone No.: _________________________ Fax No.: _____________________________

Contact Person: ____

Psychiatrist Requesting ECT: ____

Agency: ____

Work Address: ____

Telephone No.: ___________________________ Fax No.: _____________________________

If requested by contract agency: ____

Printed Name / Signature of Contract Agency's Medical Director

Patient's Name: ____

Insurance ID Number (list if not MediCal/MediCare): _____________ DOB: ______________

- ☐ VMC Medical Record/Unicare Number: ____________________________________
- ☐ Identifying Information (Age, Marital Status, Living Situation, LPS legal status)

  ____

- ☐ DSM V Diagnoses: ____
- ☐ Can Patient Receive ECT on an Outpatient Basis? ☐ Yes ☐ No
  (if yes, list if any special needs including transportation)

  ____

- ☐ Brief Clinical History (Psychiatric Hospitalizations, medication history, Medications Major Medical Condition(s), Substance Use History if Applicable, and past response to ECT) ____

  Note: *Reason(s) for Planned Hospital Admission (Must meet Medi-Cal necessity criteria for inpatient stay – Consult with Dr. Tiffany Ho in advance)*

Approved By

Tiffany Ho, MD
Medical Director
Santa Clara County Behavioral Health Services

Date: ___________

APPENDIX 10: Level I Appeal Letter Requirements

Date must be within 90 Calendar Days of Receipt of Denial

Date

Name of Inpatient Psychiatric Provider

Name/Title of Sender
List Address
List Phone and Fax numbers

Attention: Appeals Coordinator

ICMC UR Department
County of Santa Clara
828 South Bascom Avenue
San Jose Ca, 95128-2600

Request for First Level Appeal regarding *Name* ***of Beneficiary***

Date of Birth	
Medi-cal ID #	
TAR Number	
Service Dates	Record Admission and Discharge Dates
Denied Service Dates	Record Denied Dates
Requested First Level Appeal Review Dates	Record Denied dates you would like to submit for First Level Appeal review ***Please specify whether you are requesting acute or Administrative Days***

Dear Sir or Madam,

Name of Inpatient psychiatric Provider received a denial of payment for inpatient psychiatric care for the above listed beneficiary.

We are requesting a first level appeal for service dates (specify service dates and whether you are requesting review for acute or administrative days).

> ***In this section address your rationale for why each service dates denied met medical necessity.***
>
> ***We recommend that you address each denied service date separately.***

Please let me know if you need addition information from our records to process the First Level Appeal request. I can be contacted at the numbers listed above Monday through Friday during business hours at the numbers listed above. Thank you for your consideration of this request.

Sincerely,
Name and Title