INPATIENT OPERATIONS HANDBOOK FOR CHILD AND ADOLESCENT PSYCHIATRY SERVICES (CAPS)

LIVE WELL SAN DIEGO

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

This handbook is posted on the OPTUM website at https://www.optumsandiego.com
All forms referenced in this manual are posted on the above website.

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Child and Adolescent Psychiatry Services (CAPS)
INPATIENT OPERATIONS HANDBOOK

Note: Contractor shall utilize the Organizational Provider Operations Handbook (OPOH) for policy and procedural requirements. This Inpatient Operations Handbook for CAPS shall serve as an addendum to the OPOH for inpatient specific information.

GENERAL OVERVIEW

This Handbook is designed to provide the contracted Children and Adolescent Psychiatry Service (CAPS) Hospital provider with information related to the provision of inpatient hospitalization services for children and adolescent youth for Medi-Cal and uninsured indigent beneficiaries who are residents of San Diego County.

County of San Diego Behavioral Health Services (BHS), as the State contracted Behavioral Health Plan (BHP) for the County of San Diego, has entered into a contractual agreement with Contractor as a Short-Doyle/Medi-Cal Hospital to provide inpatient psychiatric services to children and adolescents up to the age of eighteen years old.

Contractor shall include psychiatric inpatient services and routine physical hospital services. Psychiatric inpatient services are provided to patients who meet criteria for acute inpatient psychiatric care, patients who need Administrative Days for placement, and patients who are no longer acute, but may need additional pre-authorized continued stay for other extenuating circumstances. BHS Quality Assurance Unit will conduct the Utilization Review for all admissions. San Diego County BHP will assume the role of the point of authorization (POA) as noted in Title 9, Section 1820.215 (2)(A). In this role as the POA, the BHP provides payment authorization for children and adolescent Medi-Cal inpatient services and service categorization for unfunded patients.

This Handbook is part of the CAPS Statement of Work (SOW) and includes information on acute inpatient services, beneficiary rights for all patients as well as utilization review requirements for Medi-Cal and unfunded patients. Contractor shall utilize the Organizational Provider Operations Handbook (OPOH) for procedures that are not specific to inpatient care. This Inpatient Operations Handbook for CAPS shall serve as an addendum to the OPOH for inpatient specific information.

The contractor is required to follow all State, Federal, and County regulations and policies for all San Diego County Medi-Cal patients as well as uninsured indigent beneficiaries who are residents of San Diego County. Medi-Cal patients from counties other than San Diego may also be treated at CAPS (SB785). Providers of services for the Mental Health Plan (MHP) of San Diego are governed by the requirements of Title 9, Chapter 11 of the California Code of Regulations, referred to in this document as Title 9.

Contractor shall be a Lanterman Petris-Short (LPS) designated facility and as such shall also comply with Welfare and Institutions Code, Chapter 2 Involuntary Treatment, and SD County LPS Designation Facility Guidelines. In addition, contractor shall work collaboratively with the County of San Diego BHS designated Inpatient Advocacy Agency to ensure adherence to all patients' rights.

SHORT DOYLE/MEDI-CAL HOSPITAL

Contractor shall be a Short Doyle/Medi-Cal hospital and as such shall follow regulations in Title 9 of the California Code of Regulations, Chapter 11, Subchapter 2, Article 2, Provision of Services. The BHS Quality Assurance Unit will enter bed day services into the Electronic Health Record (EHR) for claiming reimbursement once the BHP has authorized days for inpatient services.

County of San Diego is reimbursed for services provided by contractor through Short Doyle/Medi-Cal funding. The MHP may authorize additional continued stay approval for patients who no longer meet medical necessity criteria for Medi-Cal reimbursement. Non-medically necessary continued stays are determined by the Quality Assurance Unit based on documentation of extenuating circumstances in the beneficiary's clinical record.

TARGET POPULATION

Children and adolescent patients up to the age of eighteen may include, but are not limited to, the following groups: children, youth, including involuntary and voluntary per various state codes (Welfare and Institutions Code 5585 et seq. and 6552 et seq., etc.); acute and State Hospital populations; children and adolescents who are the responsibility of the County (Child Welfare Services or Probation Department); uninsured indigent patients; Medi-Cal eligible patients; and developmentally disabled patients needing acute psychiatric treatment.

CONTRACTOR AND COUNTY BEHAVIORAL HEALTH PLAN (BHP) RESPONSIBILITIES

CONTRACTOR

Contractor shall be responsible to ensure compliance with all aspects of service delivery including the SOW, the CAPS Inpatient Handbook and with Utilization Review requirements, as well as all relevant State and Federal Regulations.

Contractor shall ensure patients' rights in accordance with State and Federal Regulations, and County policy. Violations of patients' rights will be responded to in a timely and appropriate manner.

Contractor is responsible for determining if patient meets admission criteria and reassessing patient's involuntary status determining if retention or reversal of 5150 is appropriate at admission. Contractor shall have no right of admission refusal, provided admission criteria are met. Contractor is responsible for the initial screening, triage and admittance to CAPS for further evaluation for inpatient care. Contractor shall facilitate direct admissions from hospital emergency departments (ED), PERT, police, probation, etc. Contractor is responsible for monitoring bed usage especially during times of high census to ensure acute patients are served appropriately.

Contractor shall be responsible for performing ongoing quality review monitoring and quality assurance activities in compliance with JCAHO standards and County requirements.

The Contractor's Utilization Review Committee shall be designated for the purpose of reviewing clinical records for accuracy, quality of care, documentation standards, and inter-rater reliability on all Medi-Cal and unfunded admissions, continued stays, and adverse decisions.

BEHAVIORAL HEALTH PLAN (BHP)

The Contracting Officers Representative (COR) and the Quality Assurance Unit for BHS will monitor compliance for CAPS program services.

The County Contract BHS Fiscal Unit performs administrative fiscal monitoring.

The BHS Quality Management Unit is responsible for the CAPS Utilization Review. Final authorization for billing services to Medi-Cal will be based on compliance with Title 9 medical necessity criteria for acute psychiatric inpatient hospital and administrative day services. BHS UR/QA Specialist is the designated Point of Authorization Agent for the BHP.

The BHS designated UR/QA Specialist(s) shall have access to clinical records and files, subject to State and Federal laws governing confidentiality. BHS CYF COR and QA Unit monitor contract performance and compliance with the contract requirements including, but not limited to, the utilization review requirements, the Federal Code of Regulations, the California Code of Regulations, and related policies and procedures.

The BHA Quality Assurance Unit is responsible for the evaluation, and update if necessary, of the policies and procedures addressing the authorization of SMHS at a minimum of annually. Any updates will be disclosed to BHP beneficiaries via a summary of changes attachment to the Beneficiary Handbook and to network providers via UTTM, Memo, and/or at meetings.

BENEFICIARY RIGHTS

San Diego County BHS is committed to protecting patients' rights in accordance with State and Federal Regulations and County policy. Violations of patients' rights will be responded to in a timely and appropriate manner. Contractor shall work collaboratively with the BHS designated Patient Advocate to ensure that all patients' rights are respected. Please see Section F of the OPOH for the complete details on the Grievance and Appeal process.

Confidentiality

Maintaining the confidentiality of patient and caregiver 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 BHP. Contractor shall adhere to all State and federal privacy and confidentiality laws. All privacy incidents shall be reported BHS QA Unit and the County's Health and Human Services Agency (HHSA) Privacy Officer per the OPOH.

Lanterman Petris Short Act (LPS)

Contractor shall be designated as a County of San Diego Lanterman-Petris-Short (LPS) inpatient psychiatric facility. As an LPS facility, Contractor will adhere to the most current LPS Designation Guidelines and Processes for Facilities within San Diego County which is available in the County's Technical Resource Library. https://www.sandiegocounty.gov/hhsa/programs/bhs/technical_resource_library.html or by contacting QIMatters.hhsa@sdcounty.ca.gov.

Client Guide

Provider shall offer each patient and caregiver as appropriate the Member Handbook at the patient's admission and upon request and document this activity in medical record. The handbook is entitled: *County of San Diego, Integrated Behavioral Health Member Handbook*. This handbook contains a description of the services available through the BHP, a description of the required process for obtaining services, a description of the BHP 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. This *Handbook* is distributed by the BHP. Additional copies may be obtained by calling (619) 563-2700.

All patients and caregivers shall be offered a copy of the State Handbook, "Rights for Individuals in Mental Health Facilities", from State Department of Health Care Services and documenting this activity in medical record. The 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 County's designated inpatient Patient Advocate is available to assist patients and family members with grievances and appeals. The Patient Advocate distributes an informing brochure for patients called "Seclusion & Restraint: Answers to Your Questions" when appropriate.

Patient Grievances and Appeals

Patients may contact the Inpatient Patient Advocate at 1-800-479-2233 if they are dissatisfied with any aspect of inpatient services they receive under the BHP. Per Title 42, Code of Federal Regulations (CFR), Part 438, Subpart F, the Provider is required to follow the Grievance and Appeal Process. It is the provider's responsibility to inform patients regarding their right to file a grievance or an appeal either verbally or in writing. Patient shall be able to express dissatisfaction with BHP services without negative consequences of any kind. Providers are required to post Grievance and Appeal posters (in Chinese, English, Korean, Somali, Spanish, Vietnamese, Arabic, Tagalog, Russian, and Persian) in a visible area to ensure patients are advised of their rights. Federal regulations require that all providers ensure that these brochures are easily 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 posters and brochures may be obtained by contacting the BHP at (619) 563-2700. Inpatient providers are required to maintain a log in

which all patient or caregiver grievances are entered. Concerns may be expressed verbally or in writing. The log shall 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
- The BHP may request a copy of a provider's Grievance Log at any time.

Patient Right to Request a State Fair Hearing

Medi-Cal beneficiaries must exhaust the BHP's appeal process prior to requesting a State hearing. A beneficiary has the right to request a State hearing only after receiving notice that the Plan is upholding an adverse benefit determination. Beneficiaries may file a State hearing also if the BHP does not meet specific timelines during the appeal process. Providers are required to inform their patients or the patients' conservators/legal guardians of these rights. For the complete process, refer to Section F of the OPOH.

Patient Right to Have an Advance Health Care Directive

All new patients shall be provided with the information regarding the right to have an Advance Health Care Directive at their first face-to-face contact for services and documenting activity in the medical record. This procedure applies to emancipated minors and patients 18 years and older. Generally, Advance Directives address how physical health care should be provided when an individual is incapacitated by a serious physical health care condition, such as a stroke or coma, and unable to make medical treatment decisions. The MHP provides an informational brochure on Advance Directives, available in the threshold languages, and copies may be obtained through the BHP by calling (619) 563-2700.

Patient Right to Translation Service Availability

According to Title 9, and Title IV, Civil Rights Act of 1964, interpreter services shall be available to patients 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. Interpreter services are available to all patients and their families if provider's staff is unable to provide translation services. To access interpreter services, refer to OPOH, Section C- Accessing Services for instructions.

Advising

What is the minor's legal status?

Is this minor a ward/dependent? OR: Does this minor have a parent/guardian who is legally responsible?

A. Wards and Dependents:

1. If the minor is a Ward/Dependent:
   a. Age of minor is not a factor for wards/dependents—the process is the same, regardless of age.
   b. The minor will most likely be admitted pursuant to a 72-hour hold.

2. Before the end of the first day of admission to the facility:

   a. Contact the minor's dependency attorney to provide notice of the minor's admission, and to request that the attorney counsel the minor regarding voluntary treatment.

      i) The phone number to the Children's Legal Services of San Diego is: 858-221-0404.
      ii) The person who answers the phone at the Children's Legal Services of San Diego can identify who the person's attorney is.

b. If the dependency attorney cannot be reached, or does not return call before the end of caller's shift, contact the inpatient Patient Advocate during that same day to provide notice of the minor's admission, and to request that a patient advocate counsel the minor regarding voluntary treatment.

    i) The phone number to the Patient Advocacy Program is: 619-282-1134 or 800-479-2233. Patient advocates are available at this number Monday through Friday, 8:00 to 5:00.
    ii) If it is after business hours, including the weekend, Patient Advocacy Program Director can be reached at: 619-300-2222.

c. It is necessary to contact the attorney/patient advocate early in the admission and prior to the end of the 72-hour hold.

3. When contacting the Children's Legal Services of San Diego attorney or the inpatient Patient Advocate to have the attorney or advocate counsel the minor regarding voluntary treatment, have the following form available:

    a. APPLICATION FOR APPROVAL OF A MINOR'S REQUEST FOR VOLUNTARY INPATIENT PSYCHIATRIC TREATMENT (W & I Code § 6552)

    b. When the minor speaks with the attorney or advocate, the attorney or advocate is advising the minor of the minor's right to accept treatment on a voluntary basis.

    If the dependent minor wants to stay at CAPS:

        i) If the minor, after speaking with the attorney or advocate, agrees to accept treatment on a voluntary basis, minor signs the Application.

            a) Fax the signed copy to the person (attorney or advocate) who advised the minor.

                - The fax number for Children's Legal Services of San Diego: 858-277-1350
                - The fax number for Patient Advocacy Program: 619-282-4885

            b) After the attorney or advocate receives the signed application via fax, the attorney or advocate will sign the second page of the Application, and fax the signed second page back to CAPS.

                - At this point, the minor's legal status is "voluntary."

    If the dependent minor does not want to stay at CAPS:

        i) If the minor, after speaking with the attorney or advocate, does not agree to accept treatment on a voluntary basis, no signatures are obtained from minor.
        ii) Minor should still be on a 72-hour hold.
        iii) By the end of the 72-hour hold, one of the following things needs to occur:

            a) The minor changes his/her mind and wants to stay on a voluntary basis, and, after speaking again with the attorney or advocate, agrees to accept treatment on a voluntary basis.
            b) The minor is discharged from CAPS.
            c) The physician evaluates the minor, determines that the minor meets the criterion for a 14-day hold, and all of the proper steps are taken to place the minor on a 14-day hold.

                - If the minor is placed on a 14-day hold, contact the court at that time (even if it is after hours, or on the weekend) in order to notify the court of the hold, and the need for a Certification Review Hearing.

- The court clerk can be reached at: 619- 557-5600.
- If the minor is placed on a 14-day hold, there will be a court hearing within four days (unless the minor is discharged, or agrees to voluntary admission prior to the hearing)

B. Does minor have a parent/guardian who holds legal responsibility?

1. Has the parent consented to admission of the minor?

Where there is a parent/guardian who is legally responsible for the minor, and the parent has ***not*** consented to admission, the age of the minor does not matter for the following process:

a. If the parent has ***not*** consented to admission, by the end of the 72-hour hold, one of the following things needs to occur:

i) The minor is discharged from CAPS **OR**

ii) The physician evaluates the minor, determines that the minor meets the criterion for a 14-day hold, and all of the proper steps are taken to place the minor on a 14-day hold.

a) If the minor is placed on a 14-day hold, contact the court at that time (even if it is after hours, or on the weekend) in order to notify the court of the hold and the need for a Certification Review Hearing.

b) The court clerk can be reached at: 619- 557-5600.

c) If the minor is placed on a 14-day hold, there will be a court hearing within four days (unless the minor is discharged).

Where there is a parent/guardian who is legally responsible for the minor, and the parent ***has*** consented to admission, the age of the minor ***does*** matter for the following process regarding: Roger S. advisement:

a. Is the minor under 14 years old?

i) If the minor is under 14 years old, and his/her parents or legal guardian have consented to admission, he/she is not entitled to a certification review hearing or a Roger S. hearing.

- No need to call Patient Advocacy for advisement

b. Is the minor 14 years or older?

i) The right to a Roger S. hearing applies to minors who are 14 years or older, and whose parents/legal guardian, have consented to treatment.

ii) Once parental consent for admission has been obtained, the right to a Roger S. hearing is automatically triggered—unless the minor waives his/her right to a hearing, a hearing must be scheduled.

iii) Once parental consent for admission has been obtained, call the Patient Advocacy Program to request a Roger S. Advisement.

a) Before calling the Patient Advocacy Program, have the **WAIVER OF ADMINISTRATIVE HEARING FOR HOSPITALIZATION OF A MINOR** form available

- Write the name of the minor and the birth date of the minor at the top of the form

- Completed form is faxed to the Patient Advocacy Program, regardless if the minor wants a hearing or not.

b) The phone number for the Patient Advocacy Program is: 619-282-1134.

c) The fax number for the Patient Advocacy Program is: 619-282-4885.

i) After the patient advocate speaks with the minor, the patient advocate will inform staff whether the minor wants to proceed with his/her right to have a Roger S. Hearing, or whether the minor waives the right to his/her Roger S. Hearing

ii) If the minor wants to have a Roger S. Hearing, call the court that same day to request a Roger S. Hearing (even if it is after hours or the weekend).

a) The court clerk can be reached at: 619- 557-5600.

b) A Roger S. Hearing will occur within 5 days of advisement, unless the minor is discharged prior to the hearing.

iii) After the minor speaks with the patient advocate, fill out the **WAIVER OF ADMINISTRATIVE HEARING FOR HOSPITALIZATION OF A MINOR** form.

a) If the minor does not want a hearing:

- Staff fill out: **PART B: FOR WAIVERS COMPLETED WHEN THE MINOR'S RIGHT ADVISOR WAS NOT PRESENT**

- Minor fill out: **PART C: CERTIFICATION OF STATEMENT**

b) If the minor wants a hearing, sign the bottom, where it states: **Patient refused to sign. Patient wants a Roger S. Hearing.**

iv) Fax the **WAIVER OF ADMINISTRATIVE HEARING FOR HOSPITALIZAION OF A MINOR** form to the inpatient Patient Advocate at: 619-282-4885.

Right to a Writ Hearing

1. Patients may also have the right to a writ hearing.

a. If you have any questions about writ hearings, please feel free to contact the Patient Advocacy Program at: 619-282-1134.

MEDICAL RECORD REQUIREMENTS

The Contractor shall maintain compliance with the Federal Code of Regulations (CFR 42), the California Code of Regulations (Title 9), and the contract between San Diego County Behavioral Health Plan and the Department of Health Care Services. Each individual's medical record must include at least the following:

1) Identification data (i.e. name, age, date of birth, address, telephone number, Medi-Cal beneficiary number when applicable, date of admission, etc.)

2) Evaluation/assessment, both psychiatric and physical.

3) A Title 9 Included Diagnosis from the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

4) Treatment Plan signed by patient and caregiver if available and psychiatrist within 3 business days of admission.

5) Name of medical staff member(s) responsible for individual's care.

6) Progress notes shall document the array of services provided to each patient including current symptoms and functional impairment, current risk factors, evidence of continued medical necessity, proposed interventions, patients' response to treatment and progress toward the specific goals and objectives of the treatment plan.

7) Each record entry shall be dated and signed using appropriate job titles and licenses.

8) Record entries must be legible.

9) Medical doctors must be clearly identified.

10) Unlicensed professional staff and medical student entries shall be co-signed. (Resident physicians do not require a co-signature).

11) All other pertinent health record information

12) Admission note and ongoing daily notes shall demonstrate medical necessity for acute and administrative inpatient care. (written by both MD's and clinical support staff)

13) Discharge summary shall be completed for all discharged patients.

14) All patient documentation shall be completed on the same day service is claimed for reimbursement. Documentation shall be completed in a timely manner to ensure concurrent review process is not impeded.

UTILIZATION REVIEW PLAN

The County's BHS Utilization Review Plan for CAPS is established in compliance with the authority of Federal laws and regulations, Joint Commission on Accreditation of Hospital Standards, State of California Department of Healthcare Services (DHCS), and in accordance with California Welfare and Institutions Code (W&I) as well as the California Code of Regulations (CCR) Short-Doyle/Medi-Cal (SD/MC) Utilization Review Requirements and Procedures.

The Contractor shall be licensed by the State of California and shall be a County of San Diego designated Lanterman-Petris-Short (LPS) facility. CAPS is a County contracted program that provides comprehensive acute psychiatric inpatient and administrative day services for child and adolescent residents of San Diego County and out of county youth (under authority of SB785) who are in need of psychiatric care in a secure environment.

Utilization Review is the responsibility of both the Contractor and the BHS QA Unit. The BHS UR/QA Specialist(s) is the designated agent for the Point of Authorization (POA) for payment.

Purpose

Utilization Review is an administrative responsibility required by contract and mandated by Federal and State law for the purpose of systematically monitoring the appropriateness and quality of admissions, continued stay and health services rendered to children and adolescents of a culturally diverse population within San Diego County.

Objectives

The objectives of the Utilization Review Plan shall be:

- To perform utilization review for all children and adolescents receiving services at CAPS

- To determine medical necessity for acute level of care, quality of care, and appropriateness of health care services in accordance with Federal and State laws and regulations

- To ensure that available resources, facilities, and services are being used efficiently and effectively.

- To identify factors that will lead to more efficient utilization of facilities or services.

Scope

This utilization review requirement applies to all children and adolescents in the target population receiving mental health services in the CAPS inpatient hospital. This requirement includes:

- **Acute Inpatient Care Days (Procedure Code 118**): Days that meet criteria for medical necessity for inpatient hospitalization and are eligible for reimbursement by Short Doyle/MediCal (SD/MC), Realignment, or other funding sources.

- **Administrative Days (Procedure Code 124**): Days the patient's stay at the inpatient facility (CAPS) must be continued beyond the patient's need for acute care while waiting for placement at a lesser level of care treatment facility (only applicable to Medi-Cal beneficiaries).

- **Non-Medically Necessary County Approved Days (Procedure Code 163**): Days the voluntary patient stays that continue beyond the acute phase for health and safety of the patient due to extenuating circumstances.

UTILIZATION REVIEW PROCESS

BHS UR/QA Specialist(s) act as the designated point of authorization (POA) agent for utilization review to determine medical necessity and quality of care. BHS UR/QA Specialist(s) shall have access to the patient's medical record in order to make POA determination. Clinical staff must be licensed in the State of California as a Registered Nurse, Licensed Clinical Social Worker, Marriage and Family Therapist, or a Licensed Clinical Psychologist. This designated UR staff must be familiar with inpatient medical necessity regulations detailed in the CCR, Title 9, Chapter 11, Section 1820.205.

Payment authorization shall be approved or denied within 14 days of request.

Utilization Review Designee Restrictions

Code of Federal Regulations, Title 42, Subchapter C, Subpart D, Sections 456.206

No person having a financial interest in any mental health hospital may serve as the UR designee.

Requirement for Utilization Review Record

1) Identification of the patient.

2) The name of the patient's physician.

3) The dates of admission and discharge.

4) Assessment and basis of determination of acute medical necessity for admission.

5) The plan of care is signed by patient and caregiver when available and licensed MD (non-licensed MD require co-signature) within 3 business days following date of admit, required under CFR 456.180. (Weekends and Holidays excluded)

6) Initial and subsequent continued stay review dates described under CFR 456.233 and 456.234.

7) Justification and plan for continued stay for each inpatient day, if the attending physician believes continued stay is necessary

8) Multiuse Complete Feedback Loop (copy of McFloop**)** when one has been generated.

9) Other supporting materials that the UR designee believes appropriate to be included in the record.

10) Discharge Summary.

11) Payment Authorization Request Form completed with type of day requested- (acute, administrative, and non-medically necessary).

Behavioral Health Plan's Point of Authorization

The County BHS UR/QA Specialist(s) is the designated agent for point of authorization for acute and administrative days for all patients, however, only Medi-Cal beneficiaries are submitted for reimbursement from the State.

Utilization Review Records Kept by Behavioral Health Plan

Code of Federal Regulations, Title 42, Subchapter C, Subpart D, Sections 456.211 (a-g);
California Code of Regulations, Title IX, Chapter 11, Section 1820.210.

The County of San Diego's Behavioral Health Plan will retain utilization records, requests for payment and payment authorizations on all Medi-Cal patients. UR records shall also be retained on all unfunded patients.

CONTRACTOR UTILIZATION MANAGEMENT

The County shall pay compensation for services performed by Contractor for CAPs upon the County's receipt and approval of the properly completed claim and cost report forms for the period. Refer to OPOH for additional information regarding claims and billing.

Contractor shall conform to Federal, State, and County regulations. Contractor is to maintain complete and adequate records to support utilization of services.

Objectives

The objectives of CAPS Utilization Management processes shall be:

- To demonstrate medical necessity, level of care, quality of care, and appropriateness of health care services that are in accordance with Federal and State laws and regulations.

- To ensure that available resources, facilities, and services are being used efficiently and effectively.

MEDICAL NECESSITY CRITERIA

Admission Requirement

Acute admission documentation shall be entered into the medical record within twenty-four hours for the day of admission. Documentation of continued medical necessity or Administrative Day shall be entered into the medical record on a daily basis. In addition, each day's entries in the patient's medical record will be monitored for adherence for acute medical necessity criteria, or administrative day criteria when applicable.

The beneficiary shall meet medical necessity criteria for inpatient services as set forth in Title 9 Section 1820.205 below:

1. One of the following Title 9 ICD-10 Included Diagnoses in the Diagnostic and Statistical Manual of Mental Disorders, DSM, Current Edition, published by the American Psychiatric Association:

    - Pervasive Developmental Disorders
    - Disruptive Behavior and Attention Deficit Disorders
    - Feeding and Eating Disorders of Infancy or Early Childhood
    - Tic Disorders
    - Elimination Disorders
    - Other Disorders of Infancy, Childhood, or Adolescence
    - Cognitive Disorders (only Dementias with Delusions, or Depressed Mood)
    - Substance Induced Disorders, only with Psychotic, Mood, or Anxiety Disorder
    - Schizophrenia and Other Psychotic Disorders
    - Mood Disorders
    - Anxiety Disorders
    - Somatoform Disorders
    - Dissociative Disorders
    - Eating Disorders
    - Intermittent Explosive Disorder
    - Pyromania
    - Adjustment Disorders
    - Personality Disorders

2. Both the following criteria for medical necessity must be met:

    1. 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
    2. Requires psychiatric inpatient hospital services, as the result of a mental disorder, due to the indications in either a) or b) below:

        a) Has symptoms or behaviors due to a mental disorder that (one of the following):
            1) Represent a current danger to self or others, or significant property destruction.
            2) Prevent the beneficiary from providing for, or utilizing, food, clothing or shelter.
            3) Present a severe risk to the beneficiary's physical health.
            4) Represent a recent, significant deterioration in ability to function.

        b) Require admission for treatment and/or observation for one of the following which cannot safely be provided at a lower level of care:
            1) Further psychiatric evaluation.
            2) Medication treatment.
            3) Other treatment that can reasonably be provided only if the patient is hospitalized (specialized treatment).

Continued Stay Requirement

Code of Federal Regulations, Title 42, Subchapter C, Subpart D, Sections 456.211; 456.231-456.238:

The beneficiary shall meet medical necessity criteria as set forth in Title 9 Section 1820.205 below:

1. One of the following Title 9 ICD-10 Included Diagnoses in the Diagnostic and Statistical Manual of Mental Disorders, DSM, current edition, published by the American Psychiatric Association:

    - Pervasive Developmental Disorders
    - Disruptive Behavior and Attention Deficit Disorders
    - Feeding and Eating Disorders of Infancy or Early Childhood
    - Tic Disorders
    - Elimination Disorders
    - Other Disorders of Infancy, Childhood, or Adolescence
    - Cognitive Disorders (only Dementias with Delusions, or Depressed Mood)
    - Substance Induced Disorders, only with Psychotic, Mood, or Anxiety Disorder
    - Schizophrenia and Other Psychotic Disorders
    - Mood Disorders
    - Anxiety Disorders
    - Somatoform Disorders
    - Dissociative Disorders
    - Eating Disorders
    - Intermittent Explosive Disorder
    - Pyromania
    - Adjustment Disorders
    - Personality Disorders

2. If criteria one is met, must also then meet both (a) and (b) below:

    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 1) or 2) below:

        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:
        a. Further psychiatric evaluation.
        b. Medication treatment.
        c. Other treatment that can reasonably be provided only if the patient is hospitalized.

3. Serious adverse reaction to medications, procedures or therapies requiring continued hospitalization

4. Need for continued medical evaluation or treatment that can only be provided if the beneficiary remains in a hospital.

County (BHP) Approved Non-Acute/Non-Admin Inpatient Day Request

Patients who do not meet *Title 9 Medical Necessity* criteria for Acute or Administrative day requirements for inpatient care, may be authorized for continued stay by the County's BHP due to extenuating circumstances. These days are not eligible for reimbursement by Short-Doyle/Medi-Cal, however, are not calculated into the threshold percentage obligated by the contract. County Approved days are determined by the QM UR/QA Specialists upon review of the daily documentation. Prior authorization and/or request forms are no longer required.

Short-Doyle Medi-Cal Administrative Days Policy

Administrative Day Services means psychiatric inpatient hospital services provided to only a Medi-Cal beneficiary who has been admitted to the hospital for acute psychiatric inpatient hospital services, and the beneficiary's stay at the hospital must be continued beyond the beneficiary's need for acute psychiatric inpatient hospital services due to a temporary lack of residential placement options at appropriate, non-acute treatment facilities or for those patients awaiting discharge to a confirmed residential placement

CAPS designated staff shall initiate and document placement efforts with placing agency representative and ensure that required weekly outreach to agency representatives are being conducted with collaboration of placing agency. Any exceptions shall be communicated to the BHS UR/QA Specialist(s) POA agent to avoid non-funded days. Additionally, CAPS shall work with placing agency and caregiver to ensure timely exploration of realistic residential options to facilitate prompt discharge from inpatient. BHS UR/QA Specialist(s) and COR shall be notified when prolonged utilization of administrative days is expected as it creates system wide capacity issues.

CAPS designated staff will notify BHS UR/QA Specialist of request for Administrative Days. The process is documented daily in the patient's record of need for placement. CAPS designated staff will notify placing agency regarding need for weekly submission of contacts. The contact sheet completed by the placing agency is submitted to CAPS and then forwarded to BHS UR/QA Specialist(s).

Requests for payment authorization for Administrative Day services shall be approved by the MHP when the following conditions are met in addition to requirements for timeliness of notification and any mandatory requirements of the contract negotiated between the Contractor and County BHS:

1. During the hospital stay, a beneficiary previously has met medical necessity criteria for reimbursement of acute psychiatric inpatient hospital services.

2. There is no appropriate, non-acute treatment facility in a reasonable geographic area and the medical record maintains documentation of contacts with a minimum of five appropriate, non-acute treatment facilities per week subject to the following requirements:

    a) Point of Authorization staff 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. In no case shall there be less than one contact per week. Exceptions are on a case by case basis and shall be approved by COR or designee.

    b) The lack of placement options at appropriate, non-acute residential treatment facilities and the contacts made at appropriate facilities shall be documented to include but not be limited to:

        - The status of the placement option
        - Name and Title of person contacted.
        - Date of the contact
        - Signature of the person making the contact.

3. For those beneficiaries awaiting discharge to a confirmed residential placement, Contractor shall maintain documentation of contact with the confirmed residential placement at a minimum of once per week. This documentation is to include same requirements as above stated.

If a patient is discharged to home or to the Polinsky Children's Center or if the contact sheets are not sent to the BHS UR/QA Specialist(s) by the required timeline, then Administrative Days shall be denied for payment.

Determination of Funding

Responsibility for reimbursement for mental health services rendered is determined by patient/family financial eligibility, covered services, and the Payment Authorization Request.

Financial Eligibility is determined prior to admission for care or at the time of admission. A written eligibility inquiry is completed by the designated CAPS staff. All patients shall receive a Uniform Method for Determination of Ability to Pay (UMDAP) evaluation at admission. Patients shall also be checked for Medi-Cal eligibility on admission, at the first of each month during the stay (if applicable), and at discharge. Short Doyle/Medi-Cal must be used prior to realignment funds if the patient is eligible. CAPS designated staff shall also explore whether an unfunded patient may be eligible for Medi-Cal and help facilitate that process. Realignment funding is the funding of last resort and cannot be used until all other resources are exhausted. Funding may be shifted from one source of funding to another as financial eligibility or the condition of the patient changes, or when the patient or patient's representative does not identify the patient as eligible to receive benefits and the eligibility is later discovered. This process also applies to out of county (SB785) patients being treated at CAPS.

Diagnosis and Demographic Requirements for EHR

CAPS designated staff shall enter or update a CSI Standalone Document for each client in EHR on the day of admission, but no later than 24 hours after admission. The Diagnosis form shall be entered or updated in EHR no later than 48 hours after admission. CAPS designated staff shall run the Service Error Report on a regular basis and shall correct all claims suspended due to a diagnosis or financial information issue. Suspended claims due to a diagnosis issue shall be adjudicated within three business days.

Client Plan Requirements

The medical record shall include an individualized written plan of care for each client admission. The physician shall establish a written plan of care (or client plan) prior to the authorization of payment, which must be done by the hospital Utilization Review Committee or its designee, no later than the third working day from the day of the beneficiary's admission. The physician shall sign the client plan. The client plan shall be explained to the client and the client shall be offered a copy of his/her client plan.

Discharge Planning

The Contractor shall develop and maintain a written Discharge procedure that initiates the discharge planning process on the day the patient is admitted. Discharge planning shall achieve placement at the lowest level of care reasonable in relation to health and safety of the patient. If the patient's current placement is at risk, CAPS will initiate the possibility of administrative days immediately by following the Administrative Days process. Active discharge planning shall be documented daily for each patient.

Performance of Payment Authorization

California Code of Regulations, Title 9, Chapter 11, Section 1820.215
Inpatient Hospital Services

a. Payment Authorization Process-–The BHP's POA agent is the BHS UR/QA Specialist(s) who performs payment authorization in accordance with the California Code of Regulations, Title 9, Chapter 11, Section1820.215. All reviews are conducted by a qualified and licensed reviewer and all determinations must be adequately supported by documented clinical evidence.

b. Oversight — The Quality Assurance Unit and the COR is responsible for oversight of the payment authorization process for the BHP. The CYF Supervising Psychiatrist has the responsibility for clinical oversight and doctor to doctor consultation for the UR process.

c. Payment Authorization is a current and concurrent review process to determine payment authorization of covered inpatient hospital services.

Level of Care Changes

When the patient is determined to no longer meet medical necessity criteria, the level of care changes from medically necessary (acute) to either non-medically necessary or administrative days. The non-medically necessary or administrative day level of care can return to the acute level of care if the need for acute care and medical necessity criteria can be justified and documented in the patient's record. All acute and non-medically necessary levels of care are determined concurrently upon review by the BHS UR/QA Specialist through the UR process.

The exacerbation of symptoms is not considered a new episode. The patient's acute care status is restored on the date the exacerbation is determined.

Payment Authorization Review

Code of Federal Regulations, Title 42, Subchapter C, Subpart D, Section 456.211;
California Code of Regulations, Title 9, Chapter 11, Section 1820.220(c)(2)

The patient's assignment shall be opened to CAPS unit and subunit on the day of admission and closed on the day of discharge. CAPS administration shall monitor this requirement to ensure compliance.

Contractor shall inform the BHS UR/QA Specialist(s) of each child's admission, funding source, and discharge. The UR/QA Specialist shall review the medical record daily to determine whether medical necessity is evidenced for an acute day, criteria met for an administrative day, or criteria is met for a county approved day. The UR/QA Specialist shall enter all client demographic information and UR determinations into the CAPS UM Database daily. Daily determinations for all beneficiary's are made with a description of the rationale for each determination and sent to the contractor. If there is disagreement over the UR determination, the CAPS designated staff will contact the UR/QA Specialist within one day of receiving the denial and request a re-review. If the determination is upheld by the UR/QI Specialist, the contractor may request a doctor to doctor consultation with the CYF Supervising Psychiatrist. After the doctor to doctor consultation, the Supervising Psychiatrist will inform UR/QA Specialist of the outcome. UR/QA Specialist will send final resolution to the CAPS Nurse Manager.

Payment authorization decisions shall also be made pursuant to Medical Necessity criteria.

Payment Authorization for Out of County Medi-Cal Beneficiary

CAPS shall complete the following:

a. Complete/send the 24-hour Notification Form to county of residence BHP within 24 hours of admission.

b. Submit the Treatment Authorization Request (TAR) based on the approved authorization submitted to CAPS by the UR/QA Specialist. TAR shall be processed within 30 days from date of discharge. CAPS designated staff shall email a copy of the completed TAR to the BHP UR/QA Specialist.

CONFIDENTIALITY OF MEDICAL RECORDS

Code of Federal Regulations, Title 45, Subtitle A, Subchapter C, Parts 160 &164

Contractor shall keep all records confidential and shall only disclose minutes and records in accordance with applicable state and federal laws. Patient records shall be made available for County of San Diego BHS, State Department of Health Care Services and State Department of Health Services inspection upon request, as well as relevant federal agencies. In addition, copies of reports and records must be available to Committee members, county, state, and federal surveyors.

AUDITS

Contractor is subject to San Diego County, State and Federal Audits as a provider of Short Doyle/Medi-Cal services. Contractor is expected to comply in a timely manner with all audit and monitoring requests by authorized agencies.

MEDICAL CARE EVALUATION (MCE)

Code of Federal Regulations, Title 42, Subchapter C, Subpart D, Sections 456.241-243

Medical Care Evaluation Studies shall be conducted for quality improvement and reported by the CAPS URC for analysis and consultation. At least one study shall be completed annually and at least one study shall be in progress at all times. Samples drawn for study purposes will represent a mix of Short Doyle/Medi-Cal and realignment funds patients, as well as patients with other sources of funding. The method used to select shall be the high volume, or high risk and /or problem prone children and adolescents. Analysis may be directed towards admissions, durations of stay, ancillary services furnished including drugs and biologicals, and professional services performed in the hospital.

The results of the MCE studies and how the results have been used to make changes to improve the quality of and promote a more effective and efficient use of facilities and services shall be documented and presented in the form of a report. The report will contain documentation of the analyzed data quarterly and at the end of each study. These quarterly reports on the MCE are presented at the URC which is held at least quarterly. Documentation that actions have been taken to correct or investigate further any deficiencies or problems in the review process and recommendations of more effective and efficient hospital care procedures will be provided by the responsible CAPS staff.

The MCE report shall be sent to the BHS UR/QA Specialist(s) and COR quarterly no later than the 15th day of month following the quarter ending.

MCE REPORTING BY COUNTY'S FISCAL YEAR STARTING JULY THROUGH JUNE.

MCE study information is reported to Utilization Review Committee (URC) members.

JULY	MCE Final Report DUE from previous fiscal year. Start new fiscal year MCE.
OCTOBER	MCE Update
JANUARY	MCE Update
APRIL	MCE Oral update on Final Report from current fiscal year. New MCE proposal for upcoming fiscal year DUE

UTILIZATION REVIEW COMMITTEE (URC)

Code of Federal Regulations, Title 42, Subchapter C, Subpart D, Sections 456.150-245
California Code of Regulations, Title 9, Chapter 11, Section 1820.210

The Utilization Review Committee (URC) at CAPS is a multi-disciplinary team, representing a cross-section of personnel delivering services to children and adolescents. The URC is responsible to ensure that utilization review is performed in accordance with all State and Federal regulations and requirements. The URC accomplishes this task by reviewing a sample of current Medi-Cal and unfunded admissions. Records are reviewed for quality and documentation standards and adherence to regulations regarding medical necessity for admission and continued stay. The URC reviews a sample of current Medi-Cal and unfunded charts based on the current day's census. Generally, two charts are reviewed that consist of one new admission and one continued stay. The charts are reviewed for documentation of medical necessity at admission and continued stay. If it is determined that patient no longer meets medical necessity, a McFloop will be completed and added to the URC minutes. The URC shall not be utilized as the BHPs payment authorization process, which shall be through the POA. The URC meeting shall include a report out and discussion of clinical findings form chart audits, themes or learnings from the chart audit, and status update/discussion on MCE study in process.

The URC will also review CAPS census data, significant changes in CAPS staffing and/or structure, effectiveness of clinical services, contract compliance, triage and workflow issues, clinical decision making, and any topic of importance that concerns the County of San Diego and/or CAPS regarding the CAPS contract and services.

The URC is composed of at a minimum one physician who is board certified in child psychiatry, one social worker, one psychologist, and one registered nurse. The URC shall meet a minimum quarterly or as directed by MHP's COR or designee. The URC elects a chairperson from among its members. A minimum attendance of these four staff shall be required for each URC. The chairperson conducts the URC meetings, approves and signs all minutes and correspondence.

URC is required to keep updated on State and Federal regulations as well as keeping up on current documentation standards.

BHS UR/QA Specialist(s) will attend the URC. County staff may provide updates on State and Federal regulations, feedback on adherence to regulations in the medical records, review of medical records that may demonstrate problems, and to provide technical support and trainings as applicable.

Records and Reports of the URC

Code of Federal Regulations, Title 42, Subchapter C, Subpart D, Sections 456.212(a)

a. Medical Care Evaluation Study (MCE) projects are intended to annually investigate either serious existing or potential service delivery problems. This is accomplished by using a research design consisting of predetermined document screening criteria, valid sampling techniques, analysis of findings, and recommendations for corrective action, if necessary.

b. Multi-Use Complete Feedback Loops (McFloops) are issued as a form of peer review to physicians and primary clinicians where there is a failure to adhere to regulations or lack of appropriate documentation in the clinical record to justify medical necessity. The form details the particular problem or issue and may or may not request a resolution or explanation. The feedback loop may also be used for a record after discharge only for URC inter-rater reliability purposes, completed by UR designee.

c. URC Meeting Minutes

URC Minutes

Code of Federal Regulations, Title 42, Subchapter C, Subpart D, Sections 456.212(a)

Minutes and records shall be maintained for three years. The original of the URC minutes and all attachments shall be kept on file in the CAPS administrative offices. The minutes shall include:

- Name of Committee.
- Location, date and duration of meeting.
- Names of members present and absent by discipline.
- Description of activities.
- The number of cases reviewed, including recommendations and follow-up as appropriate.
- Patient name and medical record number.
- Period of time reviewed.
- Medical Care Evaluation (MCE) studies completed or in progress of completion.
- Signature and date of the Chairperson indicating review and approval of the minutes.

Code of Federal Regulations, Title 42, Subchapter C, Subpart D, Sections 456.206

No person having a financial interest in any mental health hospital may serve as a member of the Utilization Review Committee. A Utilization Review Committee member may not review records of a patient for whom the member is directly responsible for care.

The URC Minutes shall be sent to the BHS UR/QA Specialist(s) for review at the conclusion of each URC.

Distribution to Individuals of Records and Reports

Code of Federal Regulations, Title 42, Subchapter C, Subpart D, Sections 456.212(b);
California Code of Regulations, Title IX, Chapter 11, Section 1820.220 (a).

a. Minutes are distributed to each member during the URC meeting. The URC Minutes shall be sent to the BHS UR/QA Specialist(s) for review at the conclusion of each URC. BHS UR/QA Specialist will forward Minutes to the County COR/designee.

b. Medical Care Evaluation Study reports are distributed to all members at the URC meetings. A copy is also distributed to the BHS UR/QA Specialist(s).

c. Feedback (McFloops) forms are not distributed but shall be summarized and documented in the Minutes.

Confidentiality of Records and Reports

Code of Federal Regulations, Title 42, Subchapter C, Subpart D, Section 456.213
Code of Federal Regulations, Title 45, Subtitle A, Subchapter C, Parts 160 & 164.

All records and reports shall comply with the Health Insurance Portability and Accountability Act of 1996 requirements and other State and federal laws protecting patient confidentiality and health information.

REPORTS REQUIRED

All LPS facilities are required by the State DHCS to submit the following quarterly reports to County Behavioral Health Services Quality Assurance Unit, using the State forms included in the Appendix:

- Denial of Rights/Seclusion and Restraint (DHCS 1804)—if there are no instances of denied rights in a quarter, submit report indicating zero denials.

- Quarterly Report on Involuntary Detentions.

- Convulsive Treatment Administered—to include Outpatient ECTs.

These reports should be submitted to the QA Unit by the 15th day after the end of the quarter on the forms that have been provided, both in hard copy and electronically.

In addition to the above reports required, Contractor shall also submit:

- **MONTHLY STATUS REPORTS (MSR)** - Contractor shall submit a complete and accurate Monthly Status Report (MSR) by the fifteenth (15^{th}) of the following month to the Behavioral Health Contract Administration Unit and COR/COR Analyst. Format and content of the MSR shall be as directed by CYF. Compliance shall be measured by completeness, accuracy, and timeliness. See COR Analyst for copy of CAPS MSR if needed.

DEFINITIONS

Acute Days: Medically necessary hospital inpatient days eligible for reimbursement by Short Doyle/Medi-Cal (SD/MC), Realignment, or other funding sources.

Administrative Days: The days the patient's stay at the acute inpatient facility (CAPS) must be continued beyond the patient's need for acute care while waiting for placement at a lesser level of care treatment facility.

Admission Review: A review and decision process performed by the Reviewer to determine the medical necessity and appropriateness of admission to an inpatient level of care.

Assessment: A formal, documented evaluation or analysis of the cause or the nature of the eligible patient's mental, emotional, or behavioral disorder. The assessment service is limited to intake examination, mental status evaluation, physical examination, and laboratory testing necessary for the evaluation and treatment of the eligible patient's mental health needs.

Attending Physician: The primary physician responsible for directing the care of the patient.

Behavioral Health Plan (BHP): An entity which enters into an agreement with the State DHCS to provide beneficiaries with psychiatric inpatient hospital services. An BHP may be a county, counties acting jointly or another governmental or non-governmental entity.

BHP Authorization for Payment: The initial process in which reimbursement for services provided by an acute psychiatric inpatient hospital to a beneficiary is authorized in writing by the BHP. In addition to the BHP authorization for payment, the claim must meet additional Medi-Cal requirements prior to payment.

Beneficiary: Any person certified as eligible under the Medi-Cal Program according to Section 51001. Title 22, California Code of Regulations.

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 Beneficiary: The County which currently is responsible for determining eligibility for Medi-Cal applicants or beneficiaries in accordance with Section 50120. Title 22, California Code of Regulations.

Fee For Service Medi-Cal (FFS/MC): California's Medi-Cal program that 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.

Fiscal Intermediary: The entity which has contracted with the State Department of Health Services to perform services for the Medi-Cal program pursuant to Section 14104.3 of the Welfare and Institutions Code.

Gatekeeper: Term for an organizational function which:

- Coordinates and assesses patient services needs
- Monitors services rendered to assure that only needed services are provided
- Identifies health practices and behaviors of target populations
- Creates a fixed point of responsibility
- Reduces service overlap and redundancy

Hospital: An institution, including a psychiatric health facility that meets the requirements of Section 51207, Title 22, California Code of Regulations.

Implementation Plan for Psychiatric Inpatient Hospital Services: A written description submitted to the State Department of Health Care Services (DHCS) by the Behavioral Health Plan (BHP), and approved by the DHCS, which specifies the procedures which will be used by a prospective BHP to provide psychiatric inpatient hospital services.

Inpatient Hospital Services: See Psychiatric Inpatient Hospital Services definition.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO): Now known as The Joint Commission. Is a leading independent, not-for-profit organization that accredits and certifies over 23,000 healthcare organizations and programs in the United States. The Joint Commission's mission is to continuously improve healthcare quality and safety for the public.

Lanterman-Petris-Short (LPS): Persons designated by San Diego County who may take or cause to be taken, mentally disordered person(s) into custody and place him/her in a facility designated by the County and approved by the State DHCS as a Facility for 72-hour Treatment and Evaluation.

Local Mental Health Care Plan (PLAN): The term used to denote the local managed mental health care plan administrator. The Plans will be responsible for offering an array of mental health services to all eligible Medi-Cal beneficiaries.

Managed Care: A new paradigm funding approach that combines clinical services and administrative methods in an integrated and coordinated way to provide timely access to care in a cost effective manner. Emphasis on prevention and early care reduce usage of more expensive methods of treatment.

McFloop: The Multiuse Complete Feedback Loop is issued by the Utilization Review Specialist and/or the Utilization Review Committee as a form of peer review to physicians and primary clinicians where there is a failure to adhere to regulations or lack of appropriate documentation in the clinical record. A feedback loop is a form that details what the particular problem is and asks for a resolution or explanation. The Utilization Review Committee or committee designee issues the feedback loop to the clinician only when the child is in-house. The clinician returns the feedback loop with requested information as soon as possible and under no circumstances are changes to a closed record requested. A feedback loop may be used for a record after discharge only for Utilization Review Committee inter-rater reliability purposes.

Medical Care Evaluation (MCE) Study: A study that is intended to investigate serious existing or potential service delivery problems. This is accomplished by using a research design consisting of predetermined document screening criteria, valid sampling techniques, analysis of findings, and recommendations for corrective action, if necessary.

Medical Necessity: Acute inpatient mental health services are covered benefits of realignment and Medi-Cal Programs when:

1. An individual, as a result of a suspected or established diagnosis of mental disorder, poses substantial jeopardy to self or society.
2. An individual, as a result of a suspected or established diagnosis of mental disorder, exhibits confusion, impaired judgment, or uncooperative behavior to the extent diagnostic procedures and treatment could not reasonably be assured at a lower level of care.
3. Criteria are specifically detailed in the California Code of Regulations, Title 9, Chapter 11, Section 1820.205.

Medically Necessary: A service or treatment that is appropriate and consistent with diagnosis, and that, in accordance with accepted standards of practice in the mental health community of the area in which the health services are rendered, could not have been omitted without adversely affecting the member’s condition or the quality of care rendered.

Mental Health Carve Out: It has been determined at the state level that the local County Mental Health Departments will design and develop a managed mental health care system separate from the local County Departments of Health. However, a clear mental health and health interface for integrating service delivery must be included in the design.

Non-Medically Necessary County Approved Stay: A hospital stay that continues beyond the acute phase or administrative days for the health and safety of the patient due to extenuating circumstances.

Payment Authorization Agent: The person(s) responsible for providing payment authorization to determine payment for acute and administrative days.

Payment Authorization Request: (PAR): A written form completed that documents the inpatient Short-Doyle/Medi-Cal approved payment for acute or administrative days for each patient.
Provider: A hospital, whether a Fee For Service/Medi-Cal or a Short Doyle/Medi-Cal provider, which provides psychiatric inpatient hospital services to beneficiaries.

Psychiatric Inpatient Hospital Services: Both acute psychiatric inpatient hospital services and administrative day services provided in a general acute care hospital, a free standing psychiatric hospital or a psychiatric health facility that is certified as a hospital. A free standing psychiatric hospital or psychiatric health facility that is larger than sixteen (16) beds may only be reimbursed for beneficiaries 65 years of age and over and for persons less than 21 years of age. If the person was receiving such services prior to their twenty-first birthday and they continue without interruption to require and receive such services, the eligibility for services continues to the date they no longer require such services or, if earlier, their twenty second birthday.

Primary Diagnosis: The diagnosis that is the focus of the current episode of treatment and is determined to be the reason for admission. The diagnosis must be consistent with the criteria specifically detailed in the California Code of Regulations, Title 9, Chapter 11, Section 1820.205.

Realignment Funds: Funding by the State of California to provide mental health services for patients (or their representative) that have need but lack ability to pay for their services.

Reviewer: A person authorized to review medical records for the purpose of performing Utilization Review. Authorized persons are the designated BHS UR/QA Specialist(s), BHS QA management team, and COR.

Short Doyle/Medi-Cal: Mental health insurance funded by the State of California and the Federal government for patients determined eligible by Social Services.

MENTAL HEALTH WEBSITES

County of San Diego Technical Resource Library
www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/technical_resource_library.html

Medi-Cal Website:
http://www.Medi-Cal.ca.gov

Optum San Diego:
https://www.optumsandiego.com/

Network of Care:
https://sandiego.networkofcare.org/mh/

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

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

National Alliance of Mentally Ill:
http://www.nami.org

Healthy San Diego
https://www.optumsandiego.com/content/SanDiego/sandiego/en/county-staff---providers/healthy-san-diego.html

ARC of San Diego
http://www.arc-sd.com

San Diego Regional Center
HTTP://SDRC.ORG/