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MMCD Policy Letter No. 00-01 REV.

TO:
(X) Prepaid Health Plans
(X) County Organized Health System Plans
(X) Primary Care Case Management Plans
(X) Two-Plan Model Plans
(X) Geographic Managed Care Plans

SUBJECT: MEDI-CAL MANAGED CARE PLAN RESPONSIBILITIES UNDER THE MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES CONSOLIDATION PROGRAM

PURPOSE

The purpose of this letter is to explain the contractual responsibilities of Medi-Cal managed care plans (Plan) in providing medically necessary Medi-Cal covered physical health care services to Plan members who may require specialty mental health services through the Medi-Cal Specialty Mental Health Services Consolidation program described in Medi-Cal regulations.

GOALS

The goals of this letter are:

- To provide Plans with information regarding the delivery of specialty mental health services to beneficiaries, including those enrolled in a Plan, under the Medi-Cal Specialty Mental Health Services Consolidation program through local mental health plans (MHP).

- To clarify the responsibility of Plans in developing a written agreement addressing the issues of interface with the MHP, including protocols for coordinating the care of Plan members served by both parties and a mutually satisfactory process for resolving disputes, to ensure the coordination of medically necessary Medi-Cal covered physical and mental health care services.

- To clarify the responsibilities of Plans in delivering medically necessary contractually required Medi-Cal covered physical health care services to Plan members who may require specialty mental health services through the Medi-Cal Specialty Mental Health Services Consolidation program.

BACKGROUND

In Fiscal Year 1991-92, legislation was enacted that allowed the Department of Health Services (DHS), as the single state agency with the authority to administer the Medicaid program in California, to establish new managed care programs for the delivery of Medi-Cal services to beneficiaries.

Subsequent legislation required DHS, in consultation with DMH, to ensure that all systems for Medi-Cal managed care include a process for screening, referral, and coordination with medically necessary mental health services. The statute designated DMH as the state agency responsible for the development and implementation of a plan to provide local mental health managed care for Medi-Cal beneficiaries; and further required DMH to implement managed mental health care through fee-for-service (FFS) or capitated rate contracts negotiated with MHPs. A MHP could include a county, counties acting jointly, any qualified individual or organization, or a non-governmental agency contracting with DMH and sharing in the financial risk of providing mental health services; however, counties were given the right of first refusal for MHP contracts.

DMH, with input from a broad range of stakeholders, developed a plan for the provision of Medi-Cal managed mental health care at the local level that consolidated two separate systems of mental health care service delivery; the Medi-Cal FFS system, which allowed clients a free choice of providers, and the Short-Doyle/Medi-Cal system administered through the county mental health departments. By consolidating the two systems of care and their separate funding streams, it was felt that the Medi-Cal program would both improve care coordination and reduce administrative costs.

DMH implemented the first phase of managed mental health care, the consolidation of Medi-Cal inpatient mental health services at the county level, in January 1995.

Because it restricted Medi-Cal beneficiaries' choice of providers to the MHP in their county of residence and its network of contract providers, the new mental health program required a waiver from the federal Health Care Financing Administration

(HCFA) of provisions of the Social Security Act that otherwise guarantee beneficiaries a choice of providers.

In September 1997, HCFA approved California's request to expand Medi-Cal managed mental health care to include outpatient specialty mental health services and renewed the waiver for an additional two years. DMH implemented the second phase of Medi-Cal managed mental health care, the consolidation of psychiatric inpatient hospital services and outpatient specialty mental health and certain other services, in November 1997. A request to renew the waiver for an additional two years was submitted to HCFA by DMH in June 1999.

This comprehensive program of Medi-Cal funded mental health managed care services, which is administered by DMH through an interagency agreement with DHS, is now known as the Medi-Cal Specialty Mental Health Services Consolidation program.

Currently, the county mental health department is the MHP in all 58 counties of California, although a few Plans have elected to cover some, but not all Medi-Cal covered specialty mental health services. Two MHPs, Sutter-Yuba and Placer-Sierra, cover a bi-county area. The MHP selects and credentials its provider network, negotiates rates, authorizes specialty mental health services, and provides payment for services rendered by specialty mental health providers in accordance with statewide criteria.

Under the Medi-Cal Specialty Mental Health Services Consolidation program, MHPs are financed through a combination of state, federal and local funds. ~~**However, only funding for specified outpatient specialty mental health services and inpatient psychiatric services is provided to MHPs.**~~ MHPs receive no specific Medi-Cal funding for physical health services or any mental health services not specifically covered by the Consolidation program.

Unless otherwise excluded by contract, Plans are capitated for physical health care services, including but not limited to, those services described on pages 7 through 15 and mental health services that are within the primary care physician's scope of practice. Consistent with Plan contracts, some Plans may also receive capitation for specific mental health services such as psychologist and psychiatrist professional services, psychiatric inpatient hospital services, and long-term care services including nursing facility services for Plan members whose need for such services is based on mental illness.

As the state agency responsible for the development and implementation of local Medi-Cal managed mental health care, the California Department of Mental Health (DMH) has adopted emergency regulations entitled, "Medi-Cal Specialty Mental Health Services." These regulations are at Title 9, Division 1, Chapter 11, California Code of Regulations (CCR). Chapter 11 incorporates existing rules governing the provision of Medi-Cal inpatient psychiatric services by MHPs and adds new standards for additional services. Chapter 11 also makes specific program requirements for provision of Medi-Cal outpatient specialty mental health services by MHPs.

Field Tests

Specialty mental health services are provided to Medi-Cal beneficiaries in two counties, San Mateo and Solano, through local MHPs operated by the county mental health departments under separate field test authority from HCFA.

San Mateo County is field testing the acceptance of additional financial risk of federal reimbursement based on all-inclusive case rates for Medi-Cal inpatient hospital and outpatient services. Additionally, the MHP in San Mateo County is responsible for pharmacy and related laboratory services prescribed by psychiatrists.

Solano County is field testing various managed care concepts as a subcontractor on a capitated basis to the County Organized Health System, while also providing Short-Doyle/Medi-Cal services to beneficiaries under the regular, non-waivered Medi-Cal program.

POLICY

Consistent with contract requirements, each Plan is required to enter into a memorandum of understanding (MOU) with the MHP in each county covered by the contract. Each Plan is contractually responsible for the arrangement and payment of all medically necessary Medi-Cal covered physical health care services not otherwise excluded to Medi-Cal members who require specialty mental health services.

Memorandum of Understanding Between the Plan and the MHP

The development of a written agreement that addresses the issues of interface in the delivery of Medi-Cal covered services to beneficiaries who are served by both parties is a shared Plan/MHP responsibility. Pursuant to contract requirements regarding local MHP coordination, Plans are required execute an MOU with the local MHP in each

county covered by the contract. Title 9, CCR, Section 1810.370, requires the MHP to execute an MOU with the Plan in each county served by the MHP.

The MOU is required to specify, consistent with contract requirements, the respective responsibilities of the Plan and the MHP in delivering medically necessary Medi-Cal covered physical health care services and specialty mental health services to beneficiaries. It is essential that circumstances that present a potential for unique operational difficulties be clearly addressed as components of the MOU.

It is suggested that Plans include a matrix of Plan/MHP responsibilities similar to the sample shown on Enclosure 3.

At a minimum, the MOU must address the following:

1. Referral protocols between plans, which must include:

   - How the Plan will provide a referral to the MHP when the Plan determines specialty mental health services covered by the MHP may be required;

   - How the MHP will provide a referral to a provider or provider organization outside the MHP, including the Plan, when the MHP determines that the beneficiary's mental illness does not meet the medical necessity criteria for coverage by the MHP or would be responsive to physical health care based treatment.

   - The availability of clinical consultation between a Plan and the MHP, which must include the availability of clinical consultation on a beneficiary's physical health condition. Such consultation must also include consultation by the Plan to the MHP on medications prescribed by the Plan for a Plan member whose mental illness is being treated by the MHP; and consultation by the MHP to the Plan on psychotropic drugs prescribed by the MHP for a Plan member whose mental illness is being treated by the Plan.

2. Procedures for the delivery of contractually required Medi-Cal covered inpatient and outpatient specialty mental health services through the MHP including but not limited to:

- The responsibility of the MHP relating to the prescription by MHP providers of mental heath drugs and related laboratory services that are the contractual obligation of the Plan to cover and reimburse.

- The MHP's obligation to provide the names and qualifications of the MHP's prescribing physicians to the Plan.

- Emergency room facility and related charges.

- Medical transportation services when the purpose of such transportation is to reduce the cost of psychiatric inpatient hospital services to the MHP.

- Specialty mental health services prescribed by a psychiatrist and delivered at the home of a beneficiary.

- Direct transfers between psychiatric inpatient hospital services and inpatient hospital services to address changes in a beneficiary's medical condition.

3. Procedures for the delivery by the Plan of Medi-Cal covered physical health care services that the Plan is contractually obligated to cover and are necessary for the treatment of mental health diagnoses covered by the MHP.

   These procedures must address, but are not limited to, provision of the following:

   - Outpatient mental health services within the primary care physician's scope of practice.

   - Covered ancillary physical health services to Plan members receiving psychiatric inpatient hospital services, including the history and physical required upon admission.

   - Prescription drugs and laboratory services.

   - The Plan's obligation to provide the procedures for obtaining timely authorization and delivery of prescribed drugs and laboratory services and a list of available pharmacies and laboratories to the MHP.

   - Emergency room facility and related services.

- Emergency and non-emergency medical transportation.
- Home health agency services.
- Long-term care services (to the extent that these services are included by Plan contract).
- Direct transfers between inpatient hospital services and psychiatric inpatient hospital services to address changes in a Plan member's mental health condition.

4. The appropriate management of Plan member care, including procedures for the exchange of medical records information, which maintain confidentiality in accordance with applicable state and federal laws and regulations.

5. A mutually satisfactory process for resolving disputes between the Plan and the MHP that includes a means for Plan members to receive medically necessary physical and mental health care services, including specialty mental health services and prescription drugs, while a dispute is being resolved.

   To the extent a Plan has not executed an MOU by the date of this letter or submitted an MOU to DHS for review and approval, the Plan must immediately submit documentation substantiating its good faith efforts to enter into an MOU with the MHP or provide justification for the delay in the submission of an MOU to DHS. The Plan shall submit monthly reports to DHS documenting the Plan's continuing good faith efforts to execute an MOU with the MHP, which provides justification for the delay in meeting this requirement. At its discretion, DHS may take steps to mediate closure to an impasse in the efforts of plan parties engaged in the MOU process.

   When enrollment in a Plan in any county is 2,000 beneficiaries or less, DHS may, at the request of the Plan or the MHP, grant a waiver from these requirements, provided that both the Plan and the MHP shall provide assurance that beneficiary care will be coordinated in compliance with Title 9, CCR, Section 1810.415.

Plan Responsibility For Medi-Cal Covered Physical Health Care Services

Medi-Cal covered services are those services set forth in Title 22, CCR, Chapter 3, Article 4, beginning with Section 51301, and Title 17, CCR, Division 1, Chapter 4, Subchapter 13, beginning with Section 6840.

Physical health care and physical health care based treatment ~~as defined by Title 9, CCR, Section 1810.231.1~~ means health care provided by health professionals, including non-physician medical practitioners, whose practice is predominately general medicine, family practice, internal medicine, pediatrics, obstetrics, gynecology, or whose practice is predominately a health care specialty area other than psychiatry or psychology. Physical health care does not include a physician service as described in Title 22, Section 51305, delivered by a psychiatrist, a psychologist service as described in Title 22, Section 51309, or an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental service as described in Title 22, Section 51340 or 51340.1, delivered by a licensed clinical social worker, a marriage, family and child counselor, or a masters level registered nurse for the diagnosis and treatment of mental health conditions of children under age 21.

Each Plan is contractually obligated to cover medical care needed by Medi-Cal members for mental health conditions that are within the primary care physician's scope of practice.

Each Plan is contractually obligated to assist Plan members needing specialty mental health services whose mental health diagnoses are covered by the MHP or whose diagnoses are uncertain, by referring such members to the local MHP. If a member's mental health diagnosis is not covered by the local MHP, the Plan is required to refer the member to an appropriate Medi-Cal FFS mental health provider, if known to the Plan, or to a resource in the community that provides assistance in identifying providers willing to accept Medi-Cal beneficiaries or other appropriate local provider or provider organization.

A Plan may negotiate with the MHP to provide specialty mental health services to Plan members, or through an arrangement made with the concurrence of the local MHP, DMH, and DHS, elect to include responsibility for some specialty mental health services in its contract with DHS.

Enclosure 1, Medi-Cal Managed Care Plan Specialty Mental Health Coverage Alternatives, outlines the unique arrangements some Plans have with a MHP regarding mental health services. Currently, coverage for specialty mental health services is excluded under most Plan contracts.

Plans are required to provide medical case management and cover and pay for all medically necessary Medi-Cal covered physical health care services not otherwise excluded by contract for a Plan member receiving specialty mental health services

including, but not limited to, the services listed below, and must coordinate these services with the MHP. Protocols for the delivery of these services must be addressed as a component of the MOU consistent with contract requirements. This section shall not be construed to preclude the Plan from requiring that covered services be provided through the Plan's provider network or applying utilization controls to these services, including prior authorization, consistent with the Plan's contractual obligation to provide covered services.

Physician Services

The Plan shall cover and pay for physician services as described in Title 22, Section 51305, except the physician services of mental health specialists, even if the services are provided to treat an included mental health diagnosis. The Plan is not required to cover and pay for physician services provided by psychiatrists, psychologists, licensed clinical social workers, marriage, family, and child counselors, or other specialty mental health providers. **When medically necessary, the Plan shall cover and pay for physician services provided by specialists such as neurologists.**

The Plan shall cover and pay for physician services related to the delivery of outpatient mental health services, which are within the primary care physician's scope of practice, for both Plan members with excluded mental health diagnoses and Plan members with included mental health diagnoses whose conditions do not meet the MHP medical necessity criteria.

Emergency Services and Care

The assignment of financial responsibility to the Plan or the MHP for charges resulting from ~~emergency~~ services to determine whether a psychiatric emergency exists under the conditions provided in Title 9, CCR, Section 1820.225~~, and the care and treatment necessary to relieve or eliminate the emergent condition~~ is generally determined by:

- The diagnosis assigned to the emergent condition;
- The type of professional performing the services; and
- Whether such services result in the admission of the Plan member for psychiatric inpatient hospital services **at the same or a different facility**.

It is suggested that the assignment of financial responsibility for emergency room facility charges and professional services be addressed as a component of the MOU.

Emergency Room Facility Charges and Professional Services

Financial responsibility for charges resulting from the emergency services and care of a Plan member whose condition meets the medical necessity criteria for coverage by the MHP is contractually assigned as follows:

- The Plan shall cover and pay for the facility charges resulting from the emergency services and care of a Plan member whose condition meets MHP medical necessity criteria when such services and care do not result in the admission of the member for psychiatric inpatient hospital services **or when such services result in an admission of the member for psychiatric inpatient hospital services at a different facility.**

- The MHP ~~**shall cover and pay**~~ **is responsible** for the facility charges resulting from the emergency services and care of a Plan member whose condition meets MHP medical necessity criteria when such services and care do result in the admission of the member for psychiatric inpatient hospital services **at the same facility. The facility charge is not paid separately, but is included in the per diem rate for the inpatient stay.**

- ~~**The Plan shall cover and pay for the facility charges resulting from the emergency services and care of a Plan member whose condition meets MHP medical necessity criteria at a hospital that does not provide psychiatric inpatient hospital services, when such services and care do result in the transfer and admission of the member to a hospital or psychiatric health facility that does provides psychiatric inpatient hospital services. The Plan is not responsible for the separately billable facility charges related to the professional services of a mental health specialist at the hospital of assessment. The MHP may pay this charge, depending on its arrangement with the hospital.**~~

- **The MHP is responsible for facility charges directly related to the professional services of a mental health specialist provided in the emergency room when these services do not result in an admission of the member for psychiatric inpatient hospital services at that facility or any other facility.**

- ~~The Plan shall cover and pay for the medical professional services required for the emergency services and care of a member whose condition meets MHP medical necessity criteria when such services and care do not result in the admission of the member for psychiatric inpatient hospital services.~~

- The MHP shall cover and pay for the professional services of a mental health specialist ~~required for the emergency services and care of~~ provided in an emergency room to a Plan member whose condition meets MHP medical necessity criteria or when mental health specialist services are required to assess whether MHP medical necessity is met ~~when such services and care do result in the admission of the member for psychiatric inpatient hospital services.~~

- **The Plan shall cover and pay for all professional services except the professional services of a mental health specialist, when required for the emergency services and care of a member whose condition meets MHP medical necessity criteria.**

Payment responsibility for charges resulting from the emergency services and care of a Plan member with an excluded diagnosis or for a plan member whose condition does not meet MHP medical necessity criteria shall be assigned as follows:

- The Plan shall cover and pay for the facility charges and the medical professional services required for the emergency services and care of a Plan member with an excluded diagnosis or a Plan member whose condition does not meet MHP medical necessity criteria and such services and care do not result in the admission of the member for psychiatric inpatient hospital services.

- Payment for the professional services of a mental health specialist required for the emergency services and care of a Plan member with an excluded diagnosis is the responsibility of the Medi-Cal FFS system.

Note: Effective January 1, 2000, SB 349 (Chapter 544, Statutes of 1999), redefines the definition of emergency services and care as it applies only to health care service plans where coverage for mental health is included as a benefit. SB 349 redefines the Health and Safety Code definition of emergency services and care to include an additional screening, examination, and evaluation to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric medical condition, within the capability of the facility. The provisions of SB 349 are a clarification of the

definition of emergency services and care and a clarification of an existing responsibility and not the addition of a new responsibility. SB 349 does not change the assigned responsibilities of the Plan and the MHP to pay for emergency services as described above.

Pharmaceutical Services and Prescribed Drugs

Each Plan is contractually obligated to cover and pay for pharmaceutical services and prescribed drugs, either directly or through subcontracts, in accordance with all laws and regulations regarding the provision of pharmaceutical services and prescription drugs to Medi-Cal beneficiaries, including all medically necessary Medi-Cal covered psychotropic drugs, except when provided as inpatient psychiatric hospital-based ancillary services or otherwise excluded under the Plan contract.

Each Plan must cover and pay for psychotropic drugs not otherwise excluded by the Plan's contract prescribed by out-of-plan psychiatrists for the treatment of psychiatric conditions.

A Plan may apply established utilization review procedures when authorizing prescriptions written for enrollees by out-of-plan psychiatrists; however, application of utilization review procedures should not inhibit Plan member access to prescriptions. If the Plan requires that covered prescriptions written by out-of-plan psychiatrists be filled by pharmacies in the Plan's provider network, the Plan shall ensure that drugs prescribed by out-of-plan psychiatrists are not less accessible to Plan members than drugs prescribed by network providers. ~~This~~ **These** requirement**s** should be addressed as a component of the MOU.

The Plan is not required to cover and pay for prescriptions for mental health drugs written by out-of-plan physicians who are not psychiatrists, unless these prescriptions are written by non-psychiatrists contracted by the MHP to provide mental health services in areas where access to psychiatrists is limited.

Enclosure 2 lists the prescription drugs that are currently excluded from **most** Plan contracts. Reimbursement to pharmacies for psychotropic drugs listed in Enclosure 2, and for new psychotropic drugs classified as antipsychotics and approved by the FDA, will be made through the Medi-Cal FFS system whether these drugs are provided by a pharmacy contracting with the Plan or by a FFS pharmacy provider.

Laboratory, Radiological, and Radioisotope Services

Each Plan must cover and pay for medically necessary laboratory, radiological, and radioisotope services described in Title 22, CCR, Section 51311.

The Plan must cover and pay for these services for a Plan member who requires the services of the MHP or a Medi-Cal FFS specialty mental health services provider when necessary for the diagnosis and treatment of the Plan member's mental health condition. The Plan must also cover and pay for services needed to monitor the health of members for side effects resulting from medications prescribed to treat the mental health diagnosis. The Plan must coordinate these services with the member's specialty mental health provider.

Home Health Agency Services

Each Plan must cover and pay for home health agency services as described in Title 22, CCR, Section 51337 **prescribed by a Plan provider** when medically necessary to meet the ~~**physical health care**~~ needs of homebound Plan members. A homebound Plan member as defined by Title 22, CCR, Section 51146 is one who is essentially confined to home due to illness or injury, and if ambulatory or otherwise mobile, is unable to be absent from his home except on an infrequent basis or for periods of relatively short duration.

The Plan is not obligated to provide home health agency services that would not otherwise be authorized by the Medi-Cal program, or when medication support services, case management services, crisis intervention services, or any other specialty mental health services as provided under Section 1810.247, are prescribed by a psychiatrist and are provided at the home of a beneficiary. **However, home health agency services prescribed by Plan providers to treat the mental health conditions of Plan members are the responsibility of the Plan.**

Medical Transportation Services

Each Plan must cover and pay for all medically necessary emergency and non-emergency medical transportation services as described in Title 22, CCR, Section 51323 for Plan members, including emergency and non-emergency medical transportation services required by members to access Medi-Cal covered mental health services.

Each Plan must also cover and pay for medically necessary non-emergency medical transportation services when prescribed for a Plan member by a Medi-Cal mental health provider outside the MHP.

Each MHP must arrange and pay for medical transportation when the **MHP's** purpose ~~of~~ **for** the medical transportation service is to transport a Plan member receiving psychiatric inpatient hospital services from a hospital to another hospital or another type of 24-hour care facility because the services in the facility to which the beneficiary is being transported will result in lower costs to the MHP.

Hospital Outpatient Department Services

Each Plan must cover and pay for professional services and associated room charges for hospital outpatient department services consistent with medical necessity and the Plan's contracts with its subcontractors and DHS. **Separately billable outpatient services related to E**electroconvulsive therapy**,** ~~**and related services**~~ **such as anesthesiologist services,** ~~**provided on an outpatient basis**~~ are also the contractual responsibility of the Plan.

Psychiatric Inpatient Hospital Services

Each Plan must cover and pay for all medically necessary professional services to meet the physical health care needs of Plan members who are admitted to the psychiatric ward of a general acute care hospital or to a freestanding licensed psychiatric inpatient hospital. These services include the initial health history and physical assessment required within 24 hours of admission and any medically necessary physical medicine consultations ~~**and separately billable hospital-based ancillary services for which the Plan is otherwise contractually responsible. Such services may include, but are not limited to, prescription drugs (except antipsychotics), laboratory services, x-ray, electroconvulsive therapy and related services, and magnetic resonance imaging that are received by a Plan member admitted to a hospital or psychiatric health facility for psychiatric inpatient hospital services.**~~

Plans are not required to cover and pay for room and board charges or mental health services associated with an enrollee's admission to a hospital or psychiatric health facility for psychiatric inpatient hospital services.

Nursing Facility Services

If long-term care is included by contract, a Plan must cover and pay for the room, board, and all medically necessary medical and other covered services provided to a Plan member in a nursing facility in accordance with the terms of the Plan's contract for coverage of long-term care.

Because long-term care is capitated to Plans as a service irrespective of diagnosis, this responsibility also includes coverage for Plan members whose need for nursing facility services is based on mental illness. Consistent with applicable contract requirements, Plans will initiate a disenrollment request for members whose projected length of stay in a nursing facility, including skilled nursing facilities with special treatment programs for the mentally disordered, or other long-term care residential treatment facility will exceed the term of the Plan's obligation for coverage of long-term care.

Each Plan is responsible for ensuring a member's orderly transfer to the Medi-Cal FFS system upon disenrollment, and must arrange and pay for all medically necessary contractually required Medi-Cal covered services until the disenrollment is effective.

Currently, MHPs are not contractually responsible for any nursing facility services, although consideration has been given to having MHPs cover skilled nursing facility services with special treatment programs for the mentally disordered. If MHPs assume this responsibility in the future, the Plan will continue to be contractually responsible to cover and pay for all medically necessary medical and other covered services not included under the per diem rate, consistent with a Plan's coverage obligations for long-term care.

Under current federal law, states are permitted to provide Medicaid coverage to individuals 21 years of age or under in psychiatric hospitals or to individuals 65 years of age or older in Institutions for Mental Diseases (IMD) that are psychiatric hospitals or nursing facilities. **Individuals who are receiving these services on their 21st birthday may continue to be covered until the earlier of their 22nd birthday or discharge.** The Medi-Cal program has elected to cover these services (psychiatric hospital services are covered by MHPs).

The Medi-Cal program also covers skilled nursing facility services with special treatment programs for the mentally disordered (these services are billed to the Medi-Cal FFS system using accommodation codes 11, 12, 31, and 32) for beneficiaries of any age in facilities that have not been designated as IMDs. Plans, therefore, are

responsible for these services in accordance with the terms of the Plan's contract for coverage of long-term care.

Under current federal law, states are not permitted to claim federal financial participation for any services provided to beneficiaries over the age of 21 and under the age of 65 residing in IMDs. The Medi-Cal program, however, does cover all services, except the nursing facility services themselves, as state-only Medi-Cal services (e.g., prescription drugs and doctor's visits). Plans are responsible for these services in accordance with the terms of the Plan's contract. MHPs provide medically necessary specialty mental health services (typically visits by psychiatrists and psychologists). Nursing facility services provided to individuals over the age of 21 and under the age of 65 in nursing facilities that are designated IMDs are funded by county realignment and other funds and are not Medi-Cal covered services.

When coverage for long-term care is excluded by Plan contract, or upon the expiration of the Plan's obligation under its contract to provide such services, payment is handled through the Medi-Cal FFS system.

MEDI-CAL COVERED SPECIALTY MENTAL HEALTH SERVICES

Medi-Cal covered specialty mental health services are those services defined in Title 9, CCR, Section 1810.247 ~~**delivered by a person or entity who is licensed, certified, or otherwise recognized or authorized to provide specialty mental health services under state law governing the healing arts.**~~

The scope of Medi-Cal covered specialty mental health services **covered by MHPs** is set forth in Title 9, CCR, Sections 1810.345 and 1810.350.

Access standards for Medi-Cal covered specialty mental health services **covered by MHPs** are set forth in Title 9, CCR, Section 1810.405.

Medical Necessity Criteria

Under the Medi-Cal Specialty Mental Health Services Consolidation program, each MHP is obligated to provide or arrange and pay for specialty mental health services to Medi-Cal beneficiaries of the county served by the MHP who meet specified medical necessity criteria and when specialty mental health services are required to assess whether the medical necessity criteria are met.

The medical necessity criteria are met when:

- a beneficiary has both an included diagnosis; *and*
- the beneficiaries' condition meets specified impairment and intervention criteria.

A copy of Title 9, CCR, Sections 1820.205, 1830.205, and 1830.210, which provide the medical necessity criteria for psychiatric inpatient hospital services, outpatient specialty mental health services, and specialty mental health services for beneficiaries under the age of 21 are included with this letter as Enclosure 4.

Referrals to the MHP may be received through beneficiary self-referral or through referral by another person or organization.

Beneficiaries, including Plan members, whose diagnoses are not included in the applicable listing of MHP covered diagnoses in Title 9, CCR, Section 1830.205(b)(1), may obtain specialty mental health services through the Medi-Cal FFS system under applicable provisions of Title 22, CCR, Division 3, Subdivision 1. However, under the Specialty Mental Health Services Consolidation program, beneficiaries, including Plan members, whose mental health diagnoses are covered by the MHP but whose conditions do not also meet the program impairment and intervention criteria are not eligible for specialty mental health care under the Medi-Cal program. These beneficiaries are only eligible for care from a primary care or other physical health provider. The Medi-Cal FFS program will deny claims from mental health professionals for such beneficiaries.

Plans can obtain additional information about the medical necessity criteria or the authorization and payment process for specialty mental health services by contacting the appropriate MHP.

Specialty Mental Health Services Providers

Specialty mental health services providers include, but are not limited to: licensed mental health professionals; masters level registered nurses providing EPSDT supplemental services; clinics; hospital outpatient departments; certified day treatment facilities; certified residential treatment facilities; skilled nursing facilities; psychiatric health facilities; psychiatric units of general acute care hospitals; and acute psychiatric hospitals. The Plan and the MHP are providers when employees of the Plan or the MHP provide direct services to beneficiaries.

Mental health professionals may continue to participate in the Medi-Cal FFS program, but the Medi-Cal program will only cover specialty mental health services related to mental health diagnoses that are not the responsibility of either the MHP or the Plan. Hospitals not affiliated with the MHP may provide psychiatric inpatient hospital services to Medi-Cal beneficiaries in emergency situations at FFS rates established by regulation.

Covered Specialty Mental Health Services

Covered specialty mental health services include:

- Rehabilitative Services, which include mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services;
- Psychiatric Inpatient Hospital Services;
- Targeted Case Management;
- Psychiatrist Services;
- Psychologist Services;
- EPSDT Supplemental Specialty Mental Health Services for children under the age of 21~~(including services to seriously emotionally and behaviorally disturbed children with substance abuse problems or whose emotional disturbance is related to family substance abuse)~~; and
- Psychiatric Nursing Facility Services. **(Currently, MHPs are not contractually required to provide any nursing facility services.)**

  ~~(Currently, MHPs are not contractually required to provide any nursing facility services.)~~

Many MHPs also provide services to seriously emotionally and behaviorally disturbed children with substance abuse problems or whose emotional or behavioral disturbance is related to family substance abuse.

Services Excluded From Coverage by the MHP

The MHP is not responsible to provide or arrange and pay for the services excluded from coverage by the MHP under Title 9, CCR, Section 1810.355. Plans may be responsible to arrange and pay for these services when contractually required.

Services excluded from coverage by the MHP are:

- Medi-Cal services, which are those services described in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, that are not specialty mental health services for which the MHP is responsible pursuant to Title 9, CCR, Section 1810.345.

- Prescribed drugs as described in Title 22, CCR, Section 51313, and laboratory, radiological, and radioisotope services as described in Title 22, CCR, Section 51311, except when provided as hospital-based ancillary services. Medi-Cal beneficiaries may obtain Medi-Cal covered prescription drugs and laboratory, radiological, and radioisotope services prescribed by licensed mental health professionals acting within their scope of practice and employed by or contracting with the MHP under applicable provisions of Title 22, Division 3, Subdivision 1.

- Medical transportation services as described in Title 22, CCR, Section 51323, except when the purpose of the medical transportation service is to transport a beneficiary receiving psychiatric inpatient hospital services from a hospital to another hospital or another type of 24-hour care facility because the services in the facility to which the beneficiary is being transported will result in lower costs to the MHP.

- Physician services as described in Title 22, CCR, Section 51305, that are not psychiatric services as defined in Title 9, CCR, Section 1810.240, even if the services are provided to treat a diagnosis included in Sections 1820.205 or 1830.205.

- Personal care services as defined in Title 22, CCR, Section 51183, and as may be defined by DHS as EPSDT supplemental services pursuant to Title 22, CCR, Section 51340(e)(3).

- Out-of-state specialty mental health services except when it is customary practice for a California beneficiary to receive medical services in a border community outside the State.

- Specialty mental health services provided by a hospital operated by DMH or the Department of Developmental Services.
- Specialty mental health services provided to a Medicare beneficiary eligible for Medicare mental health benefits.
- Specialty mental health services provided to a beneficiary enrolled in a Plan to the extent that specialty mental health services are covered by the Plan.
- Psychiatric inpatient hospital services received by a beneficiary when services are not billed to an allowable psychiatric accommodation code as specified in Title 9, CCR, Section 1820.100(a).
- Medi-Cal services that may include specialty mental health services as a component of a larger service package as follows:
  - Psychiatrist and psychologist services provided by adult day health centers pursuant to Title 22, CCR, Section 54325.
  - Home and community-based waiver services as defined in Title 22, CCR, Section 51176.
  - Specialty mental health services, other than psychiatric inpatient hospital services, authorized by the California Children Services (CCS) program to treat CCS eligible beneficiaries.
  - Local Education Agency services as defined in Title 22, CCR, Section 51190.4.
  - Specialty mental health services provided by Federally Qualified Health Centers, Indian Health Centers, and Rural Health Clinics.
  - Home health agency services as described in Title 22, CCR, Section 51337.

COORDINATION OF MEDI-CAL COVERED PHYSICAL HEALTH CARE SERVICES AND SPECIALTY MENTAL HEALTH SERVICES

Plan Responsibilities

The coordination of Medi-Cal covered physical health care services and specialty mental health services is a dual Plan/MHP responsibility. The Plan is responsible for arranging appropriate management of a Plan member's care between plans or with other health care providers or providers of specialty mental services as required by contract. Title 9, CCR, Section 1810.415 sets forth the requirements of the MHP in the coordination of physical and mental health care.

The Plan is responsible for the appropriate management of a Plan member's care which includes, but is not be limited to, the coordination of all medically necessary contractually required Medi-Cal covered services both within and outside the Plan's provider network, and:

- Assistance to Plan members needing specialty mental health services by referring such members to the MHP, or to an appropriate Medi-Cal FFS mental health provider or provider organization if the beneficiary is not eligible for MHP covered services or because the MHP has determined that the Plan member's mental health condition would be responsive to physical health care based treatment;

- The provision of clinical consultation and training to the MHP or other providers of mental health services on a Plan member's medical condition and on medications prescribed through Plan providers;

- Medical case management;

- The exchange of medical records information with the MHP and other providers of mental health care; and

- The coordination of discharge planning from inpatient facilities.

The Plan is required to maintain procedures for monitoring the coordination of care provided to a Plan member. When a Plan member is ineligible for MHP covered services because the member's diagnosis is not included in Title 9, CCR, Section 1830.205(b)(1) ~~, or is included but the MHP determines that the beneficiary's mental health condition would be responsive to physical health care based~~

~~treatment~~ and the Plan initiates a referral to a local provider or provider organization outside the Plan, the Plan should document such referrals in the member's medical record. The Plan is not responsible for ensuring member access to such providers, but must maintain a current list of the names, addresses, and telephone numbers of local providers and provider organizations that is available to Plan enrollees. The MHP's role in providing or assisting the Plan in the development of this list should be addressed as a component of the MOU.

A list of such sources of referral to a local provider or provider organization may include:

- **County mental health departments**
- **County departments administering alcohol and drug programs**
- **The county health and human services agency**
- **CalWorks funded programs for mental illness or substance abuse**
- **Drug Medi-Cal substance abuse services, including outpatient Heroin detoxification providers**
- **The regional center for persons who are developmentally disabled**
- **The Area Agency on Aging for referrals to services for Individuals aged 60 and over**
- **The local medical society**
- **The psychological association**
- **The mental health association**
- **Family services agencies**
- **Faith-based social services agencies**
- **Community employment and training agencies**

MHP Responsibilities

The MHP is required to make clinical consultation and training, including consultation and training on psychotropic medications, available to meet the needs of a beneficiary whose mental illness is not being treated by the MHP.

The MHP is responsible for coordinating with pharmacies and the Plan as appropriate to assist beneficiaries in receiving prescription drugs and laboratory services prescribed through the MHP, including ensuring that any medical justification required for approval of payment to the pharmacy or laboratory is provided to the authorizing entity in accordance with the authorizing entity's procedures. If a Plan requires the MHP to utilize the Plan's drug formulary when psychotropic drugs are prescribed through the MHP, such requirement should be addressed as a component of the MOU.

When **the MHP determines that** a Plan member is ineligible for MHP covered services because the member's diagnosis is not included in Title 9, CCR, Section 1830.205(b)(1), or is included but the MHP determines that the beneficiary's mental health condition would be responsive to physical health care based treatment, **the MHP is responsible to refer the member to the Plan for services covered by the Plan or to other sources of care or referral for care for services not covered by the Plan. ~~the beneficiary shall be referred to:~~ Other sources of care or referral may include:**

1. A provider outside the MHP which may include:

   - A provider with whom the beneficiary already has a patient-provider relationship;

   ~~⊟The Plan in which the beneficiary is enrolled;~~

   - A provider in the area who has indicated a willingness to accept MHP referrals, including Federally Qualified Health Centers, Rural Health Clinics, and Indian Health Clinics; or

2. An entity that provides assistance in identifying providers willing to accept Medi-Cal beneficiaries, which may include where appropriate:

   - The Health Care Options program described in Welfare and Institutions Code Section 14016.5;

- The local Child Health and Disability Prevention program as described in Title 17, Section 6800 et seq.;
- Provider organizations;
- Other community resources available in the county served by the MHP. ~~which may include, but are not limited to:~~

  ~~□County mental health departments~~

  ~~□County departments administering alcohol and drug programs~~

  ~~□The county health and human services agency~~

  ~~□CalWorks funded programs for mental illness or substance abuse~~

  ~~□Drug Medi-Cal substance abuse services, including outpatient Heroin detoxification providers~~

  ~~□The regional center for persons who are developmentally disabled~~

  ~~□The Area Agency on Aging for referrals to services for Individuals aged 60 and over~~

  ~~□The local medical society~~

  ~~□The psychological association~~

  ~~□The mental health association~~

  ~~□Family services agencies~~

  ~~□Faith-based social services agencies~~

  ~~□Community employment and training agencies~~

The MHP is not required to ensure a beneficiary's access to **physical health care based treatment or to** treatment from licensed mental health professionals for diagnoses not covered in Title 9, CCR, Section 1830.205(b)(1). ~~**When the situation generating a referral by the MHP to a provider or provider organization outside the MHP meets the criteria established in Title 9, Section 1850.210(i), a Notice of Action will be provided.**~~

Confidentiality of Medical Records Information

The Plan and the MHP are responsible for the development of protocols to maintain the confidentiality of beneficiary medical records, including all information, data, and data elements collected and maintained for the operation of the contract and shared with the other party, in accordance with all applicable federal and state laws and regulations and contract requirements.

Note: Recently enacted legislation, SB 19 (Chapter 526, Statutes of 1999), and AB 416 (Chapter 527, Statutes of 1999), expand provisions related to the confidentiality of medical records information in both the Civil Code and the Health and Safety Code.

Resolution of Disputes

The resolution of disputes is a shared Plan/MHP responsibility. The Plan is responsible for establishing procedures for the resolution of disputes with the MHP as required by contract. As set forth in Title 9, CCR, Section 1810.370, the MHP is responsible for establishing procedures for the resolution of disputes with the Plan.

When a Plan has a dispute with a MHP that cannot be resolved to the satisfaction of the Plan concerning its contractual obligations, state Medi-Cal laws and regulations, or an MOU with the MHP, the Plan may submit a request for resolution to DHS in accordance with the rules governing the resolution of disputes in Title 9, CCR, Section 1850.505. A dispute between a Plan and a MHP shall not delay medically necessary specialty mental health services, physical health care services, or related prescription drugs and laboratory, radiological, or radioisotope services to Plan members.

Additional information regarding the Medi-Cal specialty mental health managed care program may be accessed via the Internet through DMH's Web site at http://www.dmh.cahwnet.gov.

The text of the emergency regulations governing the provision of Medi-Cal specialty mental health services, and other documents pertinent to DMH's rulemaking proceedings for these regulations may be accessed through the DMH, Office of Regulations Web site at http://www.dmh.cahwnet.gov/regulations/SPEC/rulemaking.htm. The regulations will remain in effect until July 1, 2000, or until they are made permanent, whichever occurs first. The public comment period for these regulations closed on December 20, 1999. After considering all the timely and relevant comments received, DMH may adopt these regulations, or may make modifications to the text with proper notice to the public.

Substantive changes between the text of the emergency regulations on which this policy letter is based and the permanent regulations adopted, if any, will be addressed in future communication to the Plans.

Should you have questions, or require additional information regarding the content of this policy letter, please contact your contract manager.

Susanne Hughes

Susanne M. Hughes
Acting Chief
Medi-Cal Managed Care Division

Enclosures

MEDI-CAL MANAGED CARE PLAN
SPECIALTY MENTAL HEALTH COVERAGE ALTERNATIVES

Plan Type	Plan Name	County of Operation	Coverage Alternatives
Primary Care Case Management	Positive HealthCare Foundation	Los Angeles	Covers outpatient specialty mental health services and prescription drugs including psychotropic drugs
County Organized Health System	Partnership Health Plan of California*	Solano	Covers inpatient and outpatient specialty mental health services and prescription drugs including psychotropic drugs
	Santa Barbara Health Initiative	Santa Barbara	Covers prescription drugs including psychotropic drugs
	Health Plan of San Mateo**	San Mateo	Excludes drugs and related labs prescribed by the MHP
Geographic Managed Care	Kaiser Foundation Health Plan, Inc.	Sacramento	Covers inpatient and outpatient specialty mental health services and prescription drugs including psychotropic drugs
	Western Health Advantage	Sacramento	Covers outpatient specialty mental health services and prescription drugs including psychotropic drugs

* Solano County Mental Health has been a subcontractor on a capitated basis to the County Organized Health System in Solano under separate field test authority from HCFA since 1994. Mental health services are excluded by Partnership Health Plan in Napa County.

** The MHP in San Mateo County is financially responsible for prescription drugs and related laboratory services prescribed by the MHP under separate field test authority from HCFA.

Enclosure 2

DRUGS EXCLUDED FROM PLAN COVERAGE

Psychotropic Drugs	Drugs for the Treatment of HIV/AIDS
Amantadine HCL	Abacavir Sulfate (Ziagen)
Benztropine Mesylate	Amprenavir (Agenerase)
Biperiden HCL	Delaviridine Mesylate (Rescriptor)
Biperiden Lactate	Efavirenz (Sustiva)
Chlorpromazine HCL	Indinavir Sulfate (Crixivan)
Chlorprothixene	Lamivudine (Epivir)
Clozapine	Nelfinavir Mesylate (Viracept)
Fluphenazine Decanoate	Nevirapine (Viramune)
Fluphenazine Enanthate	Ritonavir (Norvir)
Fluphenazine HCL	Saquinavir (Fortovase)
Haloperidol	Saquinavir Mesylate (Invirase)
Haloperidol Decanoate	Stavudine (Zerit)
Haloperidol Lactate	Zidovudine/Lamivudine (Combivir)
Isocarboxazid	
Lithium Carbonate	
Lithium Citrate	
Loxapine HCL	
Loxapine Succinate	
Mesoridazine Besylate	
Molindone HCL	
Olanzapine	
Perphenazine	
Phenelzine Sulfate	
Pimozide	
Procyclidine HCL	
Promazine HCL	
Quetiapine	
Risperidone	
Thioridazine HCL	
Thiothixene	
Thiothixene HCL	
Tranylcypromine Sulfate	
Trifluoperazine HCL	
Triflupromazine HCL	
Trihexyphenidyl HCL	

SAMPLE

(For demonstration purposes only. Not Intended to be inclusive of all services to be addressed in an MOU between a Plan and a MHP.)

MATRIX OF MANAGED CARE PLAN/ MENTAL HEALTH PLAN RESPONSIBILITIES

Responsibility	Type of Service	Psychiatric Inpatient Hospital Medical Necessity Criteria Met	Psychiatric Inpatient Hospital Medical Necessity Criteria Not Met
Psychiatric Inpatient Hospital Services - General Acute Hospitals	Facility Charges	MHP authorization EDS or MHP payment	No MHP, MCP, or EDS payment
	Psychiatric Professional Services	MHP	No MHP, MCP, or EDS payment
	Medical Professional Services	MCP	No MHP, MCP, or EDS payment
Institutions for Mental Diseases - Acute Psychiatric Hospitals	Facility Charges Patient aged 0 to 21	MHP authorization EDS or MHP payment	No MHP, MCP, or EDS payment
	Facility Charges Patient aged 22 to 64	No MHP, MCP, or EDS payment	No MHP, MCP, or EDS payment
	Facility Charges Patient aged 65 or over	MHP authorization EDS or MHP payment	No MHP, MCP, or EDS payment
	Psychiatric Professional Services	MHP	No MHP, MCP, or EDS payment
	Medical Professional Services	MCP	No MHP, MCP, or EDS payment

SAMPLE (continued)

MATRIX OF MANAGED CARE PLAN/ MENTAL HEALTH PLAN RESPONSIBILITIES

Responsibility	Type of Service	Included Diagnosis and Meets MHP Impairment and Intervention Criteria	Excluded Diagnosis	Included Diagnosis But Does Not Meet MHP Impairment and Intervention Criteria
Emergency Departments	Facility Charges	MCP for initial triage and medical services MHP for any facility charges related to a covered psychiatric service Note: When a beneficiary is admitted to a psychiatric bed at the same facility, there is no separate payment for the ER by the MHP or the MCP	MCP	MCP
	Psychiatric Professional Services	MHP	EDS	No MHP, MCP, or EDS payment
	Medical Professional Services	MCP	MCP	MCP

California Code of Regulations
Title 9, Division 1, Chapter 11, Subchapter 3, Article 2

Section 1820.205. Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient Hospital Services.

(a) For Medi-Cal reimbursement for an admission to a psychiatric inpatient hospital, the beneficiary shall meet medical necessity criteria set forth in (1) and (2) below:
(1) One of the following diagnoses in the Diagnostic and Statistical Manual, Fourth 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) A beneficiary must have both (A) and (B):
(A) Cannot be safely treated at a lower level of care; and
(B) Requires psychiatric inpatient hospital services, as the result of a mental disorder, due to indications in either 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 psychiatric inpatient hospital shall only be reimbursed when a beneficiary experiences one of the following:
(1) Continued presence of indications which 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 which 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 psychiatric inpatient hospital.
(c) An acute patient shall be considered stable when no deterioration of the patient's condition is likely, within reasonable medical probability, to result from or occur during the transfer of the patient from the hospital.

NOTE

Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

California Code of Regulations
Title 9, Division 1, Chapter 11, Subchapter 3, Article 2

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

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

(b) The beneficiary must meet criteria outlined in (1), (2), and (3) below to be eligible for services:

(1) Be diagnosed by the MHP with one of the following diagnoses in the Diagnostic and Statistical Manual, Forth Edition, published by the American Psychiatric Association:

(A) Pervasive Developmental Disorders, except Autistic Disorders

(B) Disruptive Behavior and Attention Deficit Disorders

(C) Feeding and Eating Disorders of Infancy and Early Childhood

(D) Elimination Disorders

(E) Other Disorders of Infancy, Childhood, or Adolescence

(F) Schizophrenia and other Psychotic Disorders

(G) Mood Disorders

(H) Anxiety Disorders

(I) Somatoform Disorders

(J) Factitious Disorders

(K) Dissociative Disorders

(L) Paraphilias

(M) Gender Identity Disorder

(N) Eating Disorders

(O) Impulse Control Disorders Not Elsewhere Classified

(P) Adjustment Disorders

(Q) Personality Disorders, excluding Antisocial Personality Disorder

(R) Medication-Induced Movement Disorders related to other included diagnoses.

(2) Must have at least one of the following impairments as a result of the mental disorder(s) listed in subdivision (1) above:

(A) A significant impairment in an important area of life functioning.

(B) A probability of significant deterioration in an important area of life functioning.

(C) Except as provided in Section 1830.210, a probability a child will not progress developmentally as individually appropriate. For the purpose of this section, a child is a person under the age of 21 years.

(3) Must meet each of the intervention criteria listed below:

(A) The focus of the proposed intervention is to address the condition identified in (2) above.
(B) The expectation is that the proposed intervention will:
1. Significantly diminish the impairment, or
2. Prevent significant deterioration in an important area of life functioning, or
3. Except as provided in Section 1830.210, allow the child to progress developmentally as individually appropriate.
(C) The condition would not be responsive to physical health care based treatment.
(c) When the requirements of this section are met, beneficiaries shall receive specialty mental health services for a diagnosis included in subsection (b)(1) even if a diagnosis that is not included in subsection (b)(1) is also present.

NOTE

Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777 and 14684, Welfare and Institutions Code.

California Code of Regulations
Title 9, Division 1, Chapter 11, Subchapter 3, Article 2

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

(a) For beneficiaries under 21 years of age who do meet the medical necessity requirements of Section 1830.205(b)(2) and (3), medical necessity criteria for specialty mental health services covered by this subchapter shall be met when all of the following exist:
(1) The beneficiary meets the diagnosis criteria in Section 1830.205(b)(1),
(2) The beneficiary has a condition that would not be responsive to physical health care based treatment, and
(3) The requirements of Title 22, Section 51340(e)(3) are met; or, for targeted case management services, the service to which access is to be gained through case management is medically necessary for the beneficiary under Section 1830.205 or under Title 22, Section 51340(e)(3) and the requirements of Title 22, Section 51340(f) are met.
(b) The MHP shall not approve a request for an EPSDT Supplemental Speciality Mental Health Service under this section if the MHP determines that the service to be provided is accessible and available in an appropriate and timely manner as another specialty mental health service covered by this subchapter.
(c) The MHP shall not approve a request for specialty mental health services under this section in home and community based settings if the MHP determines that the total cost incurred by the Medi-Cal program for providing such services to the beneficiary is greater than the total cost to the Medi-Cal program in providing medically equivalent services at the beneficiary's otherwise appropriate institutional level of care, where medically equivalent services at the appropriate level are available in a timely manner.

NOTE

Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14132 and 14684, Welfare and Institutions Code; and Title 42, Section 1396d(r), United States Code.