TITLE 9. CALIFORNIA CODE OF REGULATIONS

Chapter 11. Medi-Cal Specialty Mental Health Services

1810.355. Excluded Services.

(a) MHPs shall not be responsible to provide or arrange and pay for the following services:

(1) Medi-Cal services, which are those services described in Title 22, Division 3, Subdivision 1, Chapter 3, that are not specialty mental health services as defined in Section 1810.247.

(A) Prescribed drugs as described in Title 22, Section 51313, and laboratory, radiological, and radioisotope services as described in Title 22, Section 51311, are not the responsibility of the MHPs, except when provided as hospital-based ancillary services. Medi-Cal beneficiaries may obtain Medi-Cal covered prescriptions 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.

(B) Medical transportation services as described in Title 22, Section 51323, are not the responsibility of the MHP except when the purpose of the medical transportation service is to transport a beneficiary from a psychiatric inpatient hospital to another psychiatric inpatient 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.

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

(2) 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.

(3) Specialty mental health services provided by a hospital operated by the department or the State Department of Developmental Services.

(4) Specialty mental health services provided to a beneficiary eligible for Medicare, prior to the exhaustion of beneficiary's Medicare mental health benefits. Administrative day services are excluded only if the beneficiary is in a hospital reimbursed through Medicare (Part A) based on Diagnostic Related Groups (DRGs), when the DRG reimbursement covers administrative day services according to Medicare (Part A).

(5) Specialty mental health services provided to a beneficiary enrolled in a Medi-Cal Managed Care Plan to the extent specialty mental health services are covered by the Medi-Cal Managed Care Plan.

(6) Psychiatric inpatient hospital services received by a beneficiary when services are not billed to an allowable psychiatric accommodation code as defined in Section 1820.100(a).

(7) Medi-Cal services that may include specialty mental health services as a component of a larger service package as follows:

(A) Psychiatrist and psychologist services provided by adult day health centers pursuant to Title 22, Section 54325.

(B) Home and community based waiver services as defined in Title 22, Section 51176.

(C) Specialty mental health services authorized by the California Children's Services (CCS) Program to treat CCS eligible beneficiaries.

(D) Local Education Agency (LEA) services as defined in Title 22, Section 51190.4.

(E) Specialty mental health services provided by Federally Qualified Health Centers, Indian Health Centers, and Rural Health Clinics.

(F) Home health agency services as described in Title 22, Section 51337.

(b) Beneficiaries whose diagnoses are not included in the applicable listing of diagnoses in Sections 1820.205 or 1830.205 may obtain specialty mental health services under applicable provisions of Title 22, Division 3, Subdivision 1.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Sections 5775, 5776, 5777, 5778, 5780, 14681, 14682, 14683, 14684, 14685, Welfare and Institutions Code.

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

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

(b) The beneficiary must meet criteria outlined in (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, Fourth 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 Institution Code.
Reference: Section 5777 and 14684, Welfare and Institution Code.

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 not 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 Specialty 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.

1840.312. Non-Reimbursable Services-General.

The following services are not eligible for FFP:

(a) Academic educational services

(b) Vocational services which have as a purpose actual work or work training

(c) Recreation

(d) Socialization is not reimbursable if it consists of generalized group activities which do not provide systematic individualized feedback to the specific targeted behaviors of the beneficiaries involved.

(e) Board and care costs for Adult Residential Treatment Services, Crisis Residential Treatment Services, and Psychiatric Health Facility Services.

(f) Medi-Cal program benefits that are excluded from coverage by the MHP as described in Section 1810.355.

(g) Specialty mental health services covered by this article provided during the time a beneficiary 21 years of age through 64 years of age resides in any institution for mental disease.

(h) Specialty mental health services covered by this article provided during the time a beneficiary under 21 years of age resides in an institution for mental disease other than psychiatric health facility that is a hospital as defined in this chapter or an acute psychiatric hospital, except if the beneficiary under 21 years of age was receiving such services prior to his/her twenty-first birthday. If this beneficiary continues without interruption to require and receive such services, the eligibility for FFP continues to the date he or she no longer requires such services, or if earlier, his/her twenty-second birthday. These restrictions regarding claiming FFP for services in an institution for mental disease shall cease to have effect if federal law changes or a federal waiver is obtained and reimbursement is subsequently approved.

(i) The restrictions in subsections (g) and (h) regarding claiming FFP for services to beneficiaries residing in institutions for mental disease shall cease to have effect if federal law changes or a federal waiver is obtained and claiming FFP is subsequently approved.

(j) Specialty mental health services that are minor consent services as defined in Title 22, Section 50063.5 to the extent that they are provided to beneficiaries whose Medi-Cal eligibility pursuant to Title 22, Section 50147.1 is determined to be limited to minor consent services.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Sections 5778, Welfare and Institutions Code.

1840.314. Claiming for Service Functions-General.

In order to receive FFP for provider payments made by the MHP or for services delivered directly by the MHP, the MPH must assure that the following requirements are met for all service functions:

(a) The provider must meet the applicable standards for participation in the Medi-Cal program as established under Titles XVIII and XIX of the Social Security Act.

(b) Contacts with significant support persons in the beneficiary's life are directed exclusively to the mental health needs of the beneficiary.

(c) When services are being provided to or on behalf of a beneficiary by two or more persons at one point in time, each person's involvement shall be documented in the context of the mental health needs of the beneficiary.

(d) Services shall be provided within the scope of practice of the person delivering service, if applicable.

(e) Hospital outpatient departments as defined in Title 22, Section 51112, operating under the license of a hospital may only provide service functions in compliance with licensing requirements.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Section 5778, Welfare and Institutions Code.

1840.316. Claiming for Service Functions Based on Minutes of Time.

(a) For the following services the billing unit is the time of the person delivering the service in minutes of time:

(1) Mental Health Services

(2) Medication Support Services

(3) Crisis Intervention

(4) Targeted Case Management

(b) The following requirements apply for claiming of services based on minutes of time:

(1) The exact number of minutes used by persons providing a reimbursable services shall be reported and billed. In no case shall more than 60 units of time be reported or claimed for any one person during a one-hour period. In no case shall the units of time reported or claimed for any one person exceed the hours worked.

(2) When a person provides service to, or on behalf of, more than one beneficiary at the same time, the person's time must be prorated to each beneficiary. When more than one person provides a service to more than one beneficiary at the same time, the time utilized by all those providing the service shall be added together to yield the total claimable services. The total time claimed shall not exceed the actual time utilized for claimable services.

(3) The time required for documentation and travel is reimbursable when the documentation or travel is a component of a reimbursable service activity, whether or not the time is on the same day as the reimbursable service activity.

(4) Plan development for Mental Health Services and Medication Support Services is reimbursable. Units of time may be billed regardless of whether there is a face-to-face or phone contact with the beneficiary.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Section 5778, Welfare and Institutions Code.