Mental Health Medi-Cal Specialty Mental Health Services (SMHS): Psychiatric Inpatient Hospital Services

San Francisco Mental Health Plan (SFMHP) Behavioral Health Services (BHS) Compliance Office

January 2018
<table>
<thead>
<tr>
<th>Mins</th>
<th>Item</th>
<th>Objective</th>
</tr>
</thead>
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<tr>
<td>5</td>
<td>Introductions + Agenda</td>
<td>• Establish trust and “shared vision” for training</td>
</tr>
<tr>
<td>10</td>
<td>Overview: Mental Health Medi-Cal</td>
<td>• Inpatient psych is a Rehabilitative SMHS</td>
</tr>
<tr>
<td>10</td>
<td>Psych Inpatient: Medical Necessity</td>
<td>• Required Elements and clinical pathways</td>
</tr>
<tr>
<td>10</td>
<td>Medical Necessity: #1-Diagnosis</td>
<td>• “Special Diagnosis”</td>
</tr>
<tr>
<td>15</td>
<td>Medical Necessity: #2-Not Safely Treated @ LLOC</td>
<td>• “Special Safety Level”</td>
</tr>
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<td>15</td>
<td>Medical Necessity: Impairments</td>
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</tr>
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<td>15</td>
<td>Interdisciplinary Plan of Care (IPOC) Requirements</td>
<td>• “Special Objectives”</td>
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<td>10</td>
<td>Other Insights + Self-Assessment</td>
<td>• My readiness to improve</td>
</tr>
<tr>
<td>90</td>
<td>Practice Cases + Wrap Up/Quiz</td>
<td>• Thinking through documentation (not wrote memorization)</td>
</tr>
</tbody>
</table>
• With minor exceptions, this curriculum is directly based on the DHCS (2015) curriculum that was delivered to the San Francisco Mental Health Plan in August 2015.

References & Sources of Information


ZSFGH-UM (no date). ZSFGH Inpatient Psychiatry: Clinical Scenarios for DHCS, October 2016 Audit and Plan of Correction.
MENTAL HEALTH MEDI-CAL

“Medi-Cal Insurance”

Physical Health Medi-Cal
- San Francisco Health Plan
- Blue Cross Partner. Plan
  - Physical health care
  - Mild/Moderate MH care
  - Autism Spectrum/BHT

Mental Health Medi-Cal
- BHS (County MHP)
  - SMHS
  - Moderate to severe MH care

Drug Medi-Cal/ODS
- BHS (County SUD Plan)
  - SUD Treatment Services

San Francisco Mental Health Plan (January 2018)
## MENTAL HEALTH MEDI-CAL

<table>
<thead>
<tr>
<th>Area</th>
<th>Clinic Model</th>
<th>Rehabilitation Model</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition from Federal Social Security Act</strong></td>
<td>§1905(a)(9): “Clinic services [are those] furnished by or under the direction of a <strong>physician</strong>, without regard to whether the clinic itself is administered by a physician, including such services furnished outside the clinic by clinic personnel to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address”</td>
<td>§1905(a)(13): “Other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a <strong>physician or other licensed practitioner of the healing arts</strong> (LPHA) within the scope of their practice under State law, for the <strong>maximum reduction of physical or mental disability</strong> and restoration of an individual to the best possible <strong>functional level</strong>”</td>
</tr>
<tr>
<td><strong>Treatment Model</strong></td>
<td>Medical model</td>
<td><strong>Recovery</strong> model</td>
</tr>
<tr>
<td><strong>Focus</strong></td>
<td>Stabilization</td>
<td><strong>Active treatment</strong> and <strong>participation</strong></td>
</tr>
<tr>
<td><strong>Locations</strong></td>
<td><strong>Clinic</strong>-based</td>
<td><strong>Community</strong>-based</td>
</tr>
<tr>
<td><strong>Type of Staff</strong></td>
<td><strong>Licensed</strong>: higher degree professionals</td>
<td><strong>Professionals</strong>, mental health technicians and <strong>peer</strong> specialists</td>
</tr>
<tr>
<td><strong>Organizational Model</strong></td>
<td>Organized clinics</td>
<td>Organizations that provide one or more covered services</td>
</tr>
</tbody>
</table>
MENTAL HEALTH MEDI-CAL

Clinical Practice

- Conduct assessment
- Create treatment plan
- Provide interventions

“what is the problem?”

“why problem exists”

“how to address it”

MH Medi-Cal

- Establish Diagnosis & Functional Impairments
- Create Treatment Plan/Client Plan
- Provide Treatment Interventions

“The Golden Thread” of Clinical Practice & Mental Health Medi-Cal

San Francisco Mental Health Plan (January 2018)
# PSYCH INPATIENT: Medical Necessity

- **Language/Jargon Check:** Service/Activity

<table>
<thead>
<tr>
<th>CCR Title 9</th>
<th>ZSFGH Language</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Admission</strong></td>
<td>• Acute Day</td>
<td>Medical Necessity</td>
</tr>
<tr>
<td><strong>Continued Stay</strong></td>
<td>• Acute Day</td>
<td>Medical Necessity</td>
</tr>
<tr>
<td><strong>Administrative Day Service</strong></td>
<td>• Administrative Day</td>
<td>Procedural</td>
</tr>
<tr>
<td></td>
<td>• Behavioral Day</td>
<td></td>
</tr>
<tr>
<td><strong>No Medical Necessity</strong></td>
<td>• Denied Day</td>
<td>All of the above</td>
</tr>
<tr>
<td><strong>Adverse Decision</strong></td>
<td>• Custodial Day</td>
<td></td>
</tr>
</tbody>
</table>
## PSYCH INPATIENT: Medical Necessity

### Language/Jargon Check: Levels of Care

<table>
<thead>
<tr>
<th>CCR Title 9</th>
<th>ZSFGH Language</th>
<th>Gist</th>
</tr>
</thead>
</table>
| Acute Psychiatric Inpatient | • Acute Day  
• Administrative Day | • Most restrictive  
• Stabilize/discharge |
| Crisis Stabilization-Emergency Room | • PES | • Restrictive (involuntary)  
• Stabilize |
| Crisis Residential Treatment | • Acute Diversion Unit (ADU)  
• Progress *(La Posada, Shrader, Avenues, Dore House)* | • Restrictive (voluntary)  
• Social Rehab Model |
| Crisis Stabilization-Urgent Care | • Progress Foundation *(Dore-Urgent)* | • Intensive (voluntary)  
• Social Rehab Model |
| Adult Residential Treatment | • Residential Treatment Facility/RTF | • Intensive (voluntary)  
• Social Rehab Model |
| Day Treatment (Rehabilitation & Intensive) | • Day Program  
• Progress Foundation *(Rypins)* | • Intensive (voluntary)  
• Services/supports/milieu |
| Outpatient Mental Health Services | • “Civil Service Clinics,” CBOs, Contractors  
• Includes ICM, Mobile Crisis, Private Provider Netwk | • Significant impairments  
• Least restrictive |

**Other:** “Board and Care” is a type of “Residential Care Facilities” (RCF—social-based facility, not healthcare).  
Meals, housekeeping, skilled nursing, as needed Those programs dually regulated by DSS’ Community Care Licensing and DHCS’ Long-Term Care Division (http://www.dhcs.ca.gov/services/ltc/Pages/Residential-Care-Facility-and-Adult-Residential-Facility-Provider-Enrollment.aspx)
• **Language/Jargon Check: Levels of Care**
### Jargon vs. Behaviorally-Specific

<table>
<thead>
<tr>
<th>Non-Specific Jargon</th>
<th>Behaviorally Specific Language</th>
</tr>
</thead>
<tbody>
<tr>
<td>The patient was impulsive and aggressive during community meeting, and exhibited poor impulse control on at least three occasions. Following group, the patient approached the nursing station, posturing aggressively, and spoke to the charge nurse in a threatening manner. His mood was labile, his behavior unpredictable. When redirected, he returned to the day room where he was noted to be sullen. After approximately 15 minutes, the patient became sexually inappropriate and had to be asked to return to his room. He continued to be disruptive for the remainder of the shift.</td>
<td>The patient interrupted the social worker leading the community meeting three times, and when asked to wait until the &quot;Open Discussion&quot; part of the meeting, he kicked at the empty chair in front of him. After group the patient came to the nursing station and, pointing his finger at the refrigerator, asked if he could have his morning snack. When told that the snack would be ready in 10 minutes, he went to the day room and sat silently, staring toward the nursing station. After 15 minutes, an aide reported that the patient was rubbing his genital region with his hand. He continued to ask questions at the nursing station throughout the morning, usually regarding the next smoke break, snack or meal.</td>
</tr>
</tbody>
</table>
PSYCH INPATIENT: Medical Necessity

• Jargon vs. Behaviorally Specific:

• Non-specific jargon is a primary reason for disallowance;

• BHS Quality Management’s Clinical Documentation Improvement Program (CDIP) created a tool from DHCS’ examples of jargon vs. behaviorally-specific language (see CDIP Tool #1)
Medical Necessity Criteria for SMHS Psychiatric Inpatient Hospital Services:

- “Medical necessity” is a **decision-making** criteria (for services, payment, etc.);

- **Varied definitions** of medical necessity across payers, but all reference **the provider, the service and the client** (see CDIP’s Medical Necessity Tool);

- Medical necessity in a rehabilitation model always focuses on **functional impairments and the client’s mental health needs!**
PSYCH INPATIENT: Medical Necessity

• **Medical Necessity Criteria for SMHS Psychiatric Inpatient Hospital Services:**

  • Medical necessity criteria appears in CA *State Regulation* (CCR Title 9, §1820.205);

• **Four Required Elements:**
  • Diagnosis
  • Not Safely Treated @LLOC
  • Impairments for Admission
  • Impairments for Continued Stay

• **Clinical stories ("pathways")**
  • Align your arguments, your services and documentation
PSYCH INPATIENT: Medical Necessity

- **Roadmap (see CDIP Tool #2):**

  ![Roadmap Diagram]

  **SFDPH-BHS Clinical Documentation Tools:**
  Medical Necessity for Inpatient Psychiatric Hospital SMHS in Concept & Regulation

  **Medical Necessity Required Elements & Clinical Pathways (CCR Title 9, §1820.205)**

  - **#1** Included Diagnosis
  - **#2** Cannot be Safely Treated at Lower Level of Care
  - **#3** Hospitalization due to Mental Disorder is Indicated by Either 3.1 or 3.2

  **3.1 Symptoms/Behaviors of the Mental Disorder**
  - a. Current danger to self/others/property
  - b. Prevent from providing or using food/clothing/shelter
  - c. Severe risk to client's physical health
  - d. Recent significant deterioration in functioning

  **3.2 Other Admission Reason**
  - a. Further psychiatric evaluation
  - b. Medication treatment
  - c. Other treatment that must be provided in hospital

  **#4 Continued Stay Services Meets One of the Following:**
  - a. Continued Presence of both: Requirement #2 + Requirement #3
  - b. Serious adverse reactions to: Medication, procedures or therapies requiring continued hospitalization
  - c. Presence of new indicators for both: Requirement #2 + Requirement #3
  - d. Need for continued medical evaluation or treatment: That can only be provided in a psychiatric inpatient hospital

Staff Contact: Joseph A Turner, PhD (joe.turner@sfdph.org)
Medical Necessity: DIAGNOSIS

• **Required Element #1: Diagnosis:**

  • You must *conduct a clinical assessment* to establish the diagnosis;

  • *Fill out your assessment form completely* to ensure you obtain the eleven required topics per DHCS;

  • Your treatment must focus on the *impairments that stem from the included diagnosis*;
Medical Necessity: DIAGNOSIS

• **Required Element #1: Diagnosis:**

  • Diagnosis **must appear on DHCS’ list** of included inpatient diagnoses—see CDIP Tool #3.

  ![CDIP Tool Image]

  **SFDPH-BHS Clinical Documentation Tools: DHCS' List of Included Diagnoses for Inpatient Hospital SMHS**

  **Clinical Documentation Tool:**
  
  This handout contains the current list of Inpatient Hospital Included Diagnoses for Specialty Mental Health Services (SMHS)—the list is published and maintained by DHCS.

  • **Note—this document is a tool, not a source document.** Nationally, ICD codes change in October and it’s possible that a new ICD number has been assigned to an included diagnosis.

  • Updated ICD codes would be communicated by DHCS through Information Notices—you can access the Information Notices at: [http://www.dhcs.ca.gov/formsandpubs/Pages/MHSUDS-Information-Notices.aspx](http://www.dhcs.ca.gov/formsandpubs/Pages/MHSUDS-Information-Notices.aspx)

  **Background:**

  The table below summarizes the history of ICD code changes for SMHS:

<table>
<thead>
<tr>
<th>Date</th>
<th>DHCS Source Document</th>
<th>Summary and Quoted Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 12, 2015</td>
<td>Information Notice #15-022</td>
<td>• List of frequently asked questions (FAQ) to help Counties prepare for the transition to ICD;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• “All counties, Mental Health Plans (MHP), and trading partners are required to implement ICD-10 on October 1, 2015. This transition is effective for all Short-DelayMed-Cal system claims with dates of service beginning October 1, 2015 (page 1 of IN 15-022)”</td>
</tr>
<tr>
<td>July 31, 2015</td>
<td>Information Notice #15-030</td>
<td>• First crosswalk published for providers as we transitioned from entering DSM codes to ICD codes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• “The Department of Health Care Services is issuing this Information Notice to apprise counties, direct providers, and mental health plans (MHP) of the release of the International Classification of Diseases, 10th Revision (ICD-10) Test Plan, list of included ICD-10 diagnosis codes for Substance Use Disorder (SUD) Services, and ICD-10 procedural and diagnosis crosswalk documents for Specialty Mental Health (SMH) Services” (page 1 of IN 15-036).</td>
</tr>
<tr>
<td>April 26, 2016</td>
<td>Information Notice #15-016</td>
<td>• Addition of codes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 203.89 – No Diagnosis/No Included Diagnosis/V71.09,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• R69 – Assessment in process, no diagnosis obtained yet/Diagnosis Deferred/799.9 and changes to codes (e.g., 298.7 Bipolar I Disorder, Most Recent Episode</td>
</tr>
</tbody>
</table>

San Francisco Mental Health Plan (January 2018)
**Medical Necessity: DIAGNOSIS**

**Required Element #1: Diagnosis:**

- **AUDIT RISK:** auditors look to your *discharge diagnosis*...if the admission/discharge diagnoses are different, you must describe: (a) *date of change* in dx; (b) *clinical information* that led to the change

- "*Clinical information" may include behavioral observation, interview findings, psychometric test data, laboratory studies, imaging studies, responses to treatment, newly received information about the patient’s medical/psychiatric/psychological history, and so forth. Especially important when a diagnosis changes covered to non-covered (or vice-versa)
# Medical Necessity: DIAGNOSIS

## Required Element #1: Diagnosis:

<table>
<thead>
<tr>
<th>Detail</th>
<th>Example 1: Excluded to Included</th>
<th>Example 2: Included to Excluded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admit Dx</td>
<td>Dementia of the Alzheimer's Type</td>
<td>Psychotic Disorder NOS</td>
</tr>
<tr>
<td>Discharge Dx</td>
<td>Psychotic Disorder NOS</td>
<td>Dementia of the Alzheimer's Type</td>
</tr>
<tr>
<td>Medical Record Should Include</td>
<td>• Date on which the diagnosis was changed;</td>
<td>• Date on which the diagnosis was changed;</td>
</tr>
<tr>
<td></td>
<td>• Clinical data which led to the change. In this case, for example,</td>
<td>• Clinical data which led to the change. In this case, for example,</td>
</tr>
<tr>
<td></td>
<td>the clinical data may have been:</td>
<td>the clinical data may have been:</td>
</tr>
<tr>
<td></td>
<td>• Results of an MRI which <em>revealed no diffuse</em> cortical atrophy or</td>
<td>• Results of an MRI which <em>revealed diffuse</em> cortical atrophy or</td>
</tr>
<tr>
<td></td>
<td>other pathological findings</td>
<td>other pathological findings</td>
</tr>
<tr>
<td></td>
<td>• Behavioral observations that patient had difficulty finding their</td>
<td>• Behavioral observations that patient had difficulty finding their</td>
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<tr>
<td></td>
<td>room, even after several days in the hospital</td>
<td>room, even after several days in the hospital</td>
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<tr>
<td></td>
<td>• No recognition of attending psychiatrist &amp; other medical staff</td>
<td>• No recognition of attending psychiatrist &amp; other medical staff</td>
</tr>
<tr>
<td></td>
<td>with whom he worked on a daily basis</td>
<td>with whom he worked on a daily basis</td>
</tr>
<tr>
<td>Other Issues</td>
<td></td>
<td>• The hospital stay is <em>non-reimbursable on the day that MRI results</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>became available</em> to the client’s psychiatrist or psychologist;</td>
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<tr>
<td></td>
<td></td>
<td>• Medical necessity determination hinges on the answer to this</td>
</tr>
<tr>
<td></td>
<td></td>
<td>question: <em>When should a reasonably astute clinician have</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>become aware that the correct diagnosis was an Excluded</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>diagnosis?</em></td>
</tr>
</tbody>
</table>
Medical Necessity: LLOC

- Required Element #2: Cannot be Safely Treated at Lower Level of Care (LLOC):

  “[Client] 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**”
Medical Necessity: LLOC

• Required Element #2: Cannot be Safely Treated at Lower Level of Care (LLOC):

• How to understand this? How to meet the criteria?

• Evaluate the following:

  • Client’s treatment needs

  • Range of services available at various levels of care

  • Tolerance for certain behaviors at the level of care
Medical Necessity: LLOC

- **Required Element #2: Cannot be Safely Treated at Lower Level of Care (LLOC):**

<table>
<thead>
<tr>
<th>LLOC Evaluation Element</th>
<th>Example</th>
</tr>
</thead>
</table>
| Client’s Safety Needs            | • The most common step-down facilities are crisis residential and adult residential  
|                                  | • These facilities are *not locked*, so client’s *ability to be safely treated in an open setting* needs to be determined |
| Range of Services @ LLOC         | • Although *oral PRN meds* are available in crisis/adult residential, *IM PRN medication* is generally not.  
|                                  | • Client’s *need to be treated with IM PRN* needs to be determined. |
Medical Necessity: LLOC

- **Required Element #2:** Cannot be Safely Treated at Lower Level of Care (LLOC):

<table>
<thead>
<tr>
<th>LLOC Evaluation Element</th>
<th>Example</th>
</tr>
</thead>
</table>
| Client’s Need for Assistance & Prompting | • Although residential treatment facilities do provide limited prompting and limited assistance with ADLs, but cannot handle the needs of total care patients.  
  • Client’s need for ongoing prompting and/or need for moderate/significant assistance with ADLs needs to be determined. |
# Medical Necessity: LLOC

## Required Element #2: Cannot be Safely Treated at Lower Level of Care (LLOC):

<table>
<thead>
<tr>
<th>LLOC Evaluation Element</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tolerance for Certain Behaviors @ the LOC</td>
<td>• Residential treatment facilities are not able to accept clients whose behavior is <em>grossly disorganized</em> or <em>disruptive of the treatment milieu</em>. Examples: <strong>fecal smearing, refusal to remain clothed, sexual aggression toward others, prolonged screaming/yelling.</strong></td>
</tr>
</tbody>
</table>

• Client’s *level of disorganization* and/or *disruptive behaviors* need to be determined.
Patient went AWOL from her residential placement after being "influenced by a friend." The patient was apprehended by police after she ran into traffic. She "reported SI if she had to return to her former placement." Mental Status Examination: Sixteen-year-old Hispanic female in no acute distress. Fair eye contact. Cooperative with interview, answers questions appropriately but says "I don't know" to many questions. Mood: Depressed. Suicidal Ideation: Yes, passive. Suicidal Intent: Yes, if she has to return to her former placement. Suicidal Plan: Denies active plan at this time.

Hospital Plan: Patent is appropriate for inpatient level of care for close monitoring for safety, continued adjustment in medications to target depression, and for coordination of outpatient care for continued control of symptoms after discharge.

Question: could client have been evaluated @LLOC?
Medical Necessity: LLOC

• Required Element #2: Cannot be Safely Treated at Lower Level of Care (LLOC):

  • Personal Liberty: by law, people have the right to receive services that help them to live independently and in ways that are least restrictive of personal liberty.

  • CA Welfare & Institutions Code §5325.1-§5325.1(a): Legal and Civil Rights of Persons Involuntarily Detained
Medical Necessity: LLOC

• Required Element #2: Cannot be Safely Treated at Lower Level of Care (LLOC):

• Interqual Behavioral Health Criteria 2017:

• UM staff @ZSFGH use a proprietary system to evaluate level of care determinations (Adult & Geriatric Psychiatry module).
• **Required Element #3: Hospitalization for Impairments from Mental Disorder:**

  • **SYMPTOMS** = behavioral expressions/actions associated with a disorder
    • Distractibility in a client diagnosed with ADHD;
    • Hallucinations in a client diagnosed with Schizophrenia;

  • **IMPAIRMENTS** = consequences/outcomes as a result of symptom
    • Poor school functioning due to lack of attention in class;
    • Poor social functioning due to interacting with voices;
Medical Necessity: IMPAIRMENTS

• Required Element #3: Hospitalization for Impairments from Mental Disorder:

  • *Impairments from Diagnosis* drive the Hospitalization

  • *Two Buckets of Impairments for SMHS Acute Psychiatric Inpatient:*

    3.1 Impairments from *symptoms/behaviors* of the mental disorder

    3.2 Impairments from *another admission reason* of the mental disorder
Medical Necessity: IMPAIRMENTS

• Required Element #3.1.a: Impairments from Symptoms/Behaviors-Current Danger to Self-Other-Property

• **CURRENT DANGER** (to self, others, property)

  • Lethality Assessment: ideation *and either* intent *or* plan
    • Even if the client refuses to discuss the intent/plan, you will fully document the ideation with a behaviorally-specific description of your actions, the client’s refusal behaviors, etc.

• Command Auditory Hallucinations (CAH) Assessment: presence of CAH *and also ability to resist obeying commands*
Medical Necessity: IMPAIRMENTS

• Required Element #3.1.a: Impairments from Symptoms/Behaviors-Current Danger to Self-Other-Property

  • CURRENT DANGER (to self, others, property)

  • Conditional Danger: “conditional danger” is a threat from the client that involves a condition.

  • “I feel safe here, but if I were discharged, I would kill myself by overdosing on my medications”

  • Conditional Danger Assessment: how would client react/feel about discharge to an RTF with 24hr access to staff?
Medical Necessity: IMPAIRMENTS

• Required Element #3.1.a: Impairments from Symptoms/Behaviors-Current Danger to Self-Other-Property

• CURRENT DANGER (to self, others, property)

• Conditional Danger Assessment:

  • If client **feels safe in RTF**, then hospital is not appropriate!

  • Hospital is not appropriate if client is only concerned about losing the support and professional attention and/or concerned about not having access to food, clothing and shelter?
Medical Necessity: IMPAIRMENTS

• Required Element #3.1.b: Impairments from Symptoms/Behaviors-Unable to Provide for/Utilize Food-Clothing-Shelter

• UNABLE TO UTILIZE/PROVIDE FOR (food, clothing, shelter)

• Correct Standard to Use: the standard is client’s ability to UTILIZE food, clothing, shelter

• Do not focus on ability to formulate a plan or carry out a plan since the lower level of care will be providing food, shelter, clothing, etc.
Medical Necessity: IMPAIRMENTS

- Required Element #3.1.b: Impairments from Symptoms/Behaviors-Unable to Provide for/Utilize Food-Clothing-Shelter

  - **UNABLE TO UTILIZE/PROVIDE FOR** (food, clothing, shelter)

    - Health Status Assessment: is client’s health status currently in jeopardy by refusal to eat/drink?
    - Remaining Clothed Assessment: does the client refuse to remain clothed?
• Required Element #3.1.b: Impairments from Symptoms/Behaviors-Unable to Provide for/Utilize Food-Clothing-Shelter

• **UNABLE TO UTILIZE/PROVIDE FOR** (food, clothing, shelter)

  • Public Sexual Behavior Assessment: is client engaging in sexual behavior in public?

  • Grossly Disorganized Assessment: is client’s behavior unmanageable at a lower level of care due to being grossly disorganized (e.g., smearing feces)?
Medical Necessity: IMPAIRMENTS

• Required Element #3.1.c: Impairments from Symptoms/Behaviors-Severe Risk to Health

- SEVERE RISK TO HEALTH (sx/bx due to mental d/o)
  - Connection to Diagnosis Assessment: the symptom or behavior that presents a severe risk to health is a direct result of the included diagnosis (vs. rational decision by client)
  - Anorexia (most common example) vs. Refusal to eat due to delusional beliefs (lesser common example)
  - Risk: self-proclaimed behaviors not representing current danger (e.g., “I’ll drink myself to death”)

3.1.c
Medical Necessity: IMPAIRMENTS

• Required Element #3.1.d: Impairments from Symptoms/Behaviors-Recent/Significant Deterioration in Ability to Function

• **RECENT, SIGNIFICANT DETERIORATION ABILITY TO FUNCTION**

• **Level of Care Assessment**: regardless of the deterioration, could the client have been evaluated and treated at a lower level of care?

• **Medical vs. Psychiatric Basis**: not reimbursable if deterioration is due to a medical issue
Required Element #3.2.a: Impairments from Another Admission Reason — Further Psychiatric Evaluation

- Client requires FURTHER PSYCHIATRIC EVALUATION

- Level of Care Assessment: regardless of the deterioration, could the client have been evaluated and treated at a lower level of care?

- Not for Convenience:
Medical Necessity: IMPAIRMENTS

• Required Element #3.2.b: Impairments from Another Admission Reason-Medication Treatment

  • Client requires MEDICATION TREATMENT

  • Level of Care Assessment: could the required medication treatment be provided at a lower level of care?

  • Prior Life-Threatening Reaction with Current Clinically Compelling Reason: restarting meds in Inpatient setting may be valid given past reaction and clinical reason (e.g., agranulocytosis/neuroleptic malignant syndrome)
• Required Element #3.2.c: Impairments from Another Admission Reason-Other Treatment Reasonably Provided in Hospital

• **Client requires OTHER TREATMENT THAT CAN REASONABLY BE PROVIDED ONLY IF CLIENT IS HOSPITALIZED**

  • If none of the preceding impairment criteria, then it’s unlikely the client will meet this standard;

  • Almost all treatments (e.g., ECT) can safely be provided in outpatient basis
Medical Necessity: IMPAIRMENTS

• Medical Necessity Checklist

  • Double check your work—see CDIP Tool #4!

  • Did you hit all of the following:

    • #1 Diagnosis
    • #2 Cannot be Safely Treated at a Lower Level of Care
    • #3 Impairments
Medical Necessity: Other Req’mts

• Focus of Treatment Requirement:

  • Primary focus = indicator that establishes medical necessity for admission

  • Example:
    • Admission diagnosis = Alcohol induced mood d/o
    • Impairment = danger to self (DTS)
    • Treatment focus = address dysthymia and reduce impairments that constitute DTS

  • Primary focus cannot be on preventing withdrawal symptoms (can be a secondary focus)
Medical Necessity: Other Req’mts

• Efficacy of Treatment Requirement:

  • *Planned/Delivered Treatment* must have *reasonable likelihood of reducing impairment/indicator* that establishes medical necessity for admission

  • Do not meet criteria:

    • Occupational Therapy (arts/crafts; development of fine motor skills) *as sole psychosocial treatment for client admitted with ADHD*:

    • Antipsychotic meds as *primary treatment for Intermittent Explosive Disorder (without hallucinations, delusions, thought disorder)*
• Plans of Care in SMHS—Regulatory Requirements:

• *Fill out your Plan of Care form completely* to ensure you obtain the eleven required topics per DHCS;

• Medical necessity in a rehabilitation model always focuses on *functional impairments and the client’s mental health needs!*

• *Client’s involvement, participation and agreement in treatment is prized* in a rehabilitation model.
• Plans of Care in SMHS—Regulatory Requirements:

• AUDIT RISK and ISSUES

  • Auditors consider the “Plan of Care” to be both the physician’s admitting orders as well as the IPOC

  • Plan is completed before admission/authorization; Physician’s signature on IPOC is what “establishes” the plan

  • Must be a stand-alone document (NOT in a progress note) and document must be clearly labelled as the plan.
### Psych Inpt: INTERDISCIPLINARY POC

#### Plans of Care in SMHS—CCR Title 9:

<table>
<thead>
<tr>
<th>Element</th>
<th>Gist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timely Completion of Interdisciplinary POC</td>
<td>on time!</td>
</tr>
<tr>
<td>Specific Interdisciplinary POC Objectives</td>
<td>behavioral + measurable</td>
</tr>
<tr>
<td>Proposed Interventions &amp; Detailed Description</td>
<td>individualized intervention</td>
</tr>
<tr>
<td>Frequency of Interventions</td>
<td>times per hour/day (one pill per hour)</td>
</tr>
<tr>
<td>Duration of Interventions</td>
<td>timeframe (one pill/hour for next 6mos)</td>
</tr>
<tr>
<td>Focus of Interventions</td>
<td>focus is functional impairments</td>
</tr>
<tr>
<td>Consistency of Interventions with Objectives &amp; Diagnosis</td>
<td>impairment from the mental disorder</td>
</tr>
<tr>
<td>Staff Signatures</td>
<td>wet, electronic, etc.</td>
</tr>
<tr>
<td>Client Signature</td>
<td>document involvement, agreement, etc.</td>
</tr>
<tr>
<td>Evidence of Offering Copy of Client Plan to client</td>
<td>offer a copy</td>
</tr>
<tr>
<td>Dates &amp; Staff Degree/Title on the Client Plan</td>
<td>with your wet/e-signature</td>
</tr>
</tbody>
</table>
Physician must establish written Interdisciplinary POC (prior to admission/authorization for payment)

Interdisciplinary POC must contain:

- Indications of **Need** for Admission (*diagnoses, symptoms, complaints, complications*)
- Description of **Functional Level of Client**
- **Objectives**
- **Orders** for:
  - Meds
  - Treatments
  - Restorative and rehabilitative services
  - Activities
  - Therapies
  - Social Services
  - Diet
  - Special procedures recommended for health and safety
- Plans for **Continuing Care (including review and modification)** to Interdisciplinary POC
- Plans for Discharge

90 day review (at least every 90 days) by physician/other personnel involved in client’s care
INSIGHTS: Medical Necessity

• Past Psych Hospitalizations:
  
  • You must focus on current symptoms/behaviors.

  • History of high lethality suicide attempts with hospitalization can indirectly support medical necessity if the circumstances/triggers are similar to the past.

• Medical Students:

  • Their documentation can provide confirmation of information, but licensed/waivered/registered staff should make medical necessity determinations.
INSIGHTS: Interpreter Services

• Interpreter Services: 2 Reminders

  • Hospital must *make interpreter services available* (when a client whose preferred language is non-English) so the client *can communicate with treatment staff*

  • Not family members—unless *the client specifically requests it AND ALSO refuses other options* for interpreter services.

  • Hospital must also make *interpreter services available during treatment sessions* (i.e., assessment, treatment planning meetings, individual/group sessions) when client’s preferred language is non-English)

* You must document the offer of interpreter services as well as the result (client’s refusal/acceptance, etc.)
INSIGHTS: Administrative Day Services

• Administrative Day Services: Regulations

• Standards/requirements from **CCR Title 9**—Point of Authorization [*CCR Title 9, §1820.220(j)(5)*] and Utilization Review Committee [*CCR Title 9, §1820.230(d)(2)*]

• Gist: the client’s *Inpatient mental health needs have been met*—now, the hospital is actively seeking a discharge placement;

• **DPH UM staff conduct this activity** collaboratively with discharge social workers and primary team

• Criteria: (a) at some point in the stay, the client met medical necessity; (b) five contacts with *non-acute Residential Treatment Facilities*
INSIGHTS: Administrative Day Services

• Administrative Day Services: Regulations

• “Non-acute Residential Treatment Facility” means mental health treatment is provided to all residents, on site, for a significant period of time, Monday-Friday

• “Significant period of time” is operationalized in the MHPs documentation in minutes/day.

• Non-augmented or regular board and care facilities do not qualify as residential treatment facility (nor do hotels, shelters, etc.)

• Case management does not count as treatment here

• For kids, “non-acute RTF” is a RCL level
## INSIGHTS: Administrative Day Services

- Administrative Day Services: Reimbursement

<table>
<thead>
<tr>
<th>Service</th>
<th>Reimbursement/Day</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Admission Day</strong></td>
<td>$ 7,212.00</td>
</tr>
<tr>
<td><strong>Continued Stay Day</strong></td>
<td>$ 7,212.00</td>
</tr>
<tr>
<td><strong>Administrative Day</strong></td>
<td>$ 611.60</td>
</tr>
<tr>
<td><strong>No Medical Necessity Adverse</strong></td>
<td>$ 0.00</td>
</tr>
</tbody>
</table>

San Francisco Mental Health Plan (January 2018)
INSIGHTS: Examples of Deficiencies

- Failure to meet Criteria #2 (LLOC) and #3 (Impairments):

  - Admission note describes the symptoms and behaviors from \textit{presentation to PES (vs. at admission to inpt)}. This is a significant risk!

  - For the Continued stay, \textit{you repeated the symptoms/behaviors from the Admission}…other staff documentation contradicts yours.
INSIGHTS: Examples of Deficiencies

- Failure to meet Criteria #2 (LLOC) and #3 (Impairments):

   - San Francisco Mental Health Plan (January 2018)
INSIGHTS: Examples of Deficiencies

• Failure to meet Criteria #2 (LLOC) and #3 (Impairments):
INSIGHTS: Examples of Deficiencies

• Failure to meet Criteria #2 (LLOC) and #3 (Impairments):
  
  • Symptom description is limited to non-specific jargon (+SI, AHNH, CAH, disorganized, unpredictable);
  
  • Documentation only states “at risk for self-harm, harm to others,” etc. but there is no basis for the assertion;
  
  • No assessment of vegetative signs;
  
  • Inadequate assessment of sleep characteristics and sleep pattern;
INSIGHTS: Examples of Deficiencies

• Failure to meet Criteria #2 (LLOC) and #3 (Impairments):

  • No assessment of stressors antecedent to symptom onset;

  • No assessment of resource limitations that can exacerbate the impact of stressors on the severity of the mental disorder;

  • Little or no exploration of client’s symptomatology (e.g., quality of the affective state; assessment of cognitive status);
INSIGHTS: Examples of Deficiencies

• Failure to meet Criteria #2 (LLOC) and #3 (Impairments):

  • *No apparent relationship between* client’s symptomatology and the choice of pharmacologic agent;

  • *No systematic assessment or documentation* of client’s ability to be managed at lower level of care

THE MOST FREQUENT REASONS FOR DISALLOWANCE -- both for admission and for continued stay services -- are *failure to establish* that (1) the patient could not have been treated at a lower level of care, and (2) the patient met impairment criteria for admission or continued stay services.
INSIGHTS: Examples of Deficiencies

• Problems with Treatment Plan:

  • A common error is the exclusive focus on keeping the client safe vs. the dual goals of keeping the client safe AND ALSO treating the biopsychosocial problems that caused the hospitalization;

  • “All or nothing” goals/objectives that are non-specific (“client will not have any suicidal ideation”) vs. realistic and rehabilitative goals/objectives (reduction of intensity of ideation and the development of coping skills to manage symptoms).
• Problems with Treatment Plan:

• Interventions are not customized to the client’s mental health needs, personal characteristics and the approaches that will fit for the client (i.e., they are standardized/general interventions, not individualized);

• Most interventions are milieu-based, vs. activities carried out in the context of a therapeutic relationship (e.g., group or individual work)
• Problems with Case Conceptualization:

  • Absence of case conceptualization is one of the most significant deficiencies for inpatient;

  • No documentation in chart of an attempt to understand the client’s predicament or to develop a comprehensive conceptualization that would provide an understanding of his state of mind and the reasons for his behavior.

  “Well, he was very depressed, he tried to commit suicide, he came to the hospital and he received medication treatment.”

• CDIP Tool #5 (Assessment/Formulation Improvement)
**INSIGHTS: Examples of Deficiencies**

- **Problems with Case Conceptualization:**

<table>
<thead>
<tr>
<th>Impairment</th>
<th>Goal</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMPAIRMENT 1</td>
<td>GOAL 1</td>
<td>Pt will not be a risk to herself while hospitalized.</td>
</tr>
<tr>
<td>IMPAIRMENT 2</td>
<td>GOAL 2</td>
<td>Pt. will attend and participate in daily Tx team prior to D/C.</td>
</tr>
</tbody>
</table>

### IMPAIRMENT 1
**DTS AEB pt wants P.D. to shoot her**

- **Goal 1**: Decrease frequency of suicidal ideation (from 15-20 time/hour to 5 or less time/hour); decrease intensity of ideation from 7 to 3 (scale from 1-very easy to ignore to 10-impossible to ignore and results in fantasy about specific plans)

- **Intervention 1**
  - Nursing will assess client at each shift to ensure no suicidal intent or specific plan is reported
  - If intent/plan is reported, then notify attending psychiatrist/psychologist immediately and place on line of sight observation
  - Provide safe, supportive environment. Provide opportunity for conversations with nursing/other staff on each shift
  - Encourage participation in group treatment
  - Duration: 7 hospital days

### IMPAIRMENT 2
**Alteration in cardiac output AEB pt.hx of HTN.**

- **Goal 2**: Reduce level of guilt and shame from an 8 to 4 (1=very mild feelings of guilt/shame that are easily ignored; 10=most severe ever experienced; 4 = unpleasant, but tolerable level of guilt/shame)

- **Intervention 2**
  - Discontinue Luvox that was prescribed by Outpatient team. The drug is sedating and will increase the psychomotor retardation. Start client on Prozac, 20mg, q AM. Duration = 7 hospital days

### IMPAIRMENT 3
**Hypersomnia**

- **Goal 3**: Reduce number of hours slept from 10-12 to 8-9.

- **Intervention 3-1**
  - Monitor number of hours slept during day. Encourage participation in recreational therapy. Encourage participation in group exercise prior to bedtime. Duration = 10 hospital days

### IMPAIRMENT 4
**GOAL 4**

- **Intervention 4**
  - Provide safe, supportive environment. Provide opportunity for conversations with nursing/other staff on each shift
  - Encourage participation in group treatment
  - Duration: 7 hospital days
Self-Assessment for Improvement

• Am I ready to implement improvements in my work?

• Do I have access to “source information” like training materials, tools and checklists?

• Do I have feedback on my documentation performance?

How do I get myself ready?

How do I reliably access source information?

How do I get feedback (from self/others) on performance?
PRACTICE: Prior ZSFGH Charts

- Charts audited by external reviewers (BHS; DHCS)

- **Do what the auditors do!**

  - **Diagnosis** criteria (included list; behaviorally specific)
  
  - **Safely Treated/Lower Level** criteria (referent is Crisis Residential; behaviorally specific)
  
  - **Impairment** criteria for both Admission and Continued Stay (claim your pathway; behaviorally specific)

- **see CDIP Tool #6** (ZSFGH Charts for Improvement)
# PRACTICE: Prior ZSFGH Charts

- 5 Charts audited by external reviewers (BHS; DHCS)

<table>
<thead>
<tr>
<th>#</th>
<th>Chart Details</th>
<th>Improvements</th>
</tr>
</thead>
</table>
| 1  | 61yo white male with long history of mental illness (Schizophrenia); Clini
   cian argued “Unable to Utilize” (aka grave disabled) on **Admission** |                                                                                  |
| 2  | 61yo white male with chronic psychotic disorder (Schz vs. SAD vs. BAD); Clini
   cian argued “Unable to Utilize” (aka grave disabled) on **Continued Stay** |                                                                                  |
| 3  | 54yo AA male, limited psych history, first admit to SFGH; Clini
   cian argued “Unable to Utilize” (aka grave disabled) on **Continued Stay** |                                                                                  |
| 4  | 18yo Latino male, new onset psychosis, was inpt at CPMC; first admit to SFGH; Clini
   cian did not meet **Criteria #2** (aka safely @LLOC) on **Continued Stay** |                                                                                  |
| 5  | 45yo white male with history of psychosis, probably schizophrenia and stimulant use; Clini
   cian argued “**Current Danger**” (aka DTS) on **Continued Stay** |                                                                                  |
Wrapping Up...

• **Sharing the Work:**

  • **Clinical Staff:**
    - Claim your medical necessity pathway
    - Behaviorally-specific & client-specific language
    - Review & check your work

  • **UM Staff:**
    - Confirming required elements of medical necessity (e.g., *ICD-10 diagnosis; “intent and either means or plan”*)
    - Standardized level of care determinations
Wrapping Up…

• **DHCS Audit of ZSFGH (Oct 2016) & Insights:**

  • ZSFGH-UM created a tool based on results of audit…see *handout*

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**ZSFGH Utilization Management Clinical Documentation Tools: Medical Necessity Scenarios (from October 2016 DHCS Audit & Plan of Correction)**

**BACKGROUND**

DHCS conducted a review of ZSFGH’s Acute Psychiatric Inpatient Hospital charts as part of a standard audit in October 2016.

Subsequently, ZSFGH Utilization Management (UM) took the feedback/guidance from DHCS and created two tools that can help staff understand the medical necessity for Acute Psychiatric Inpatient Hospital Services: (a) summary table with the medical necessity criteria and guidance and (b) annotated examples of actual notes.

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**SUMMARY TABLE: MEDICAL NECESSITY CRITERIA & GUIDANCE**

<table>
<thead>
<tr>
<th>Criteria to Meet</th>
<th>Guidance for Admission Day</th>
<th>Guidance for Continued Stay Service</th>
</tr>
</thead>
</table>
| **Current Danger-Self** | Must clearly state Suicidal Ideation with Intent or Plan.  
If cannot discern Intent or Plan, must clearly state why they cannot obtain.  
Example: Patient with suicidal ideation with plan to jump off the golden gate bridge if discharged from PES. | Must clearly state Suicidal Ideation with Intent or Plan.  
If cannot discern Intent or Plan, must clearly state why they cannot obtain.  
Example: Patient with continued suicidal ideation with plan to jump off the golden gate bridge if discharged from inpatient unit today. |
| **Current Danger-Others** | Must clearly state Homicidal Ideation with Intent or Plan.  
If cannot discern Intent or Plan, must clearly state why they cannot obtain.  
Must be more than a loose verbal threat.  
Example: Patient states he will kill his brother with a gun that is in his house. | Must clearly state Homicidal Ideation with Intent or Plan.  
If cannot discern Intent or Plan, must clearly state why they cannot obtain.  
Must be more than a loose verbal threat.  
Example: Patient continues to state today that he will kill his brother with a gun if he *were discharged* today. |

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Staff contacts: Amy Davidson, RN, PHN, MSN, CNL, ACM-RN (amy.davidson@sfddph.org) & Joseph A Turner, PhD (joe.turner@sfddph.org)
Wrapping Up…

• Documentation Deficiencies & Recoupment:

• “Reasons for Recoupment”: Annual publication of DHCS’ list of deficiencies that lead to “financial recoupment”

• Admission Services: did not establish #1 (dx), #2 (LLOC), #3 (impairments);

• Continued Stay Services: same as above

• Client Plan: plan is missing/not completed; physician did not sign/date plan (or timeliness of sign/date)
Wrapping Up...Quiz!
Wrap Up!

• **Acknowledgements**: UCSF clinical and administrative staff; ZSFGH/DPH Utilization Management staff; DPH Compliance & Privacy Affairs staff;

• **Questions/Thoughts?**

• **Contacts**: [chona.peralta@sfdph.org](mailto:chona.peralta@sfdph.org); [joe.turner@sfdph.org](mailto:joe.turner@sfdph.org)

• **Resources**:

  - **BHS**: [https://www.sfdph.org/dph/comupg/oservices/mentalHlth/CBHS/](https://www.sfdph.org/dph/comupg/oservices/mentalHlth/CBHS/)

  - **CDIP**: [https://www.sfdph.org/dph/comupg/oservices/mentalHlth/CBHS/CBHSQualityMgmt.asp](https://www.sfdph.org/dph/comupg/oservices/mentalHlth/CBHS/CBHSQualityMgmt.asp)