Professional Development & Training Series:
Behavioral Health Quality Assurance (BHQA) Staff

Specialty Mental Health Services:
CCR Title 9 and Medical Necessity

June 2017

San Francisco Department of Public Health
Behavioral Health Services
Quality Management
Clinical Documentation Improvement Program (CDIP)

Staff contact: Joseph A Turner, PhD (joe.turner@sfdph.org)
Problem: People Do Not Understand…

- Quality assurance…
  - Let’s learn the “theory” behind the practice (30mins)

- Managed care…
  - Let’s learn about a public model (30mins)

- Medical necessity…
  - Let’s improve our skills in this area (60mins)
Handouts

- Build a binder for workshop materials:
  - **Powerpoint**: steal these slides for your training!
  - **CDIP CCR Title 9**: a must-have reference for a true QA professional
  - **CDIP Medical Necessity Tool**: let’s standardize this work
  - **Bonus Materials**: know your history and profession. Read about SF managed care (circa 1995) and conceptual issues in medical necessity
Agency-Level Definition of QA:

- What is your **job title**?
- What are you **monitoring/improving**?
- What is the **impact of your work** (how does your work make a difference)?
- What are you **major work activities**?
### “Quality Assurance” in Your Organization

<table>
<thead>
<tr>
<th>Job Title</th>
<th>Target/Focus of Work</th>
<th>Impact of Work</th>
<th>Example Work Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director of Quality Management</td>
<td>Monitoring contract UoS + PURQC</td>
<td>Mitigate financial risk + grow business</td>
<td>Calculate/report monthly UoS (for CFO) and PURQC (for program)</td>
</tr>
</tbody>
</table>

*example above is from prior job*
Jargon Check: Quality Assurance

Quality Management

- Quality Assurance: retrospective comparison against a standard
- Quality Improvement: real-time investigation of processes
- Organized system to monitor & improve quality
Different people define QA/QI/QM differently...

...how does your organization see qa/qi/qm?

...how do managed care organizations see it?
**Managed Care**

**INSURANCE COMPANY**

*they sell you the policy*

**Step 1**

[Image of a stick figure with a happy face]

**MANAGED CARE ORG. COMPANY**

*they administer the benefits of the policy*

**Step 2**

[Image of a stick figure holding a policy]

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Staff Contact: Joseph A Turner, PhD (joe.turner@sfdph.org)
I have limited money to take care of EVERYBODY!

I can keep the savings if I manage the money well!

Step 3

Managed Care Organization Company

they hold the risk
PROVIDER

*they deliver the service*

therapist

clients

Step 4

Step 5

Invoice

• 100 Units of Therapy
• 200 Units of TCM

MANAGED CARE ORG. COMPANY

*they pay provider & save* (hopefully)

Policy

Staff Contact: Joseph A Turner, PhD (joe.turner@sfdph.org)
How Do Managed Care Organizations **Manage Their Risk?**

- **Gatekeepers!**
  - (no accessing specialists without permission)

- **Utilization Management**
  - (monitoring for too much/little)

Staff Contact: Joseph A Turner, PhD (joe.turner@sfdph.org)
Utilization Management

(monitoring for too much/little)

is the service *medically necessary*?
QA people are frequently involved in “Utilization Management”...

...balancing the needs of a population & limited dollars

...how does CA do Managed Care for Medicaid?
California’s Managed Care Medicaid: Three Benefits

“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 SUDP)
  - Specialty SUD
  - Moderate to Severe SUD care

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6/2/2017
You build a publicly funded managed care Medicaid program by following blueprints & rules!

“CCR Title 9”
(a regulation)

Blueprint
(build a County Mental Health Plan)

Rules
(operate a County Mental Health Plan)
California’s Managed Care Medicaid & CCR Title 9

### California Law

- **CA Governor**
- **CA Senate**
- **CA Assembly**

### California Regulation

- **CA Governor**

#### Dept of... Transportation, Housing and Community Development, Real Estate, Aging, Social Services, Consumer Affairs, Fish & Game, Health Care Services

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**The 27 Regulatory “Titles” of the California Code of Regulations (CCR)**

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**The 29 California Codes (California’s Statutory Law)**

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<th>Business &amp; Professions Code</th>
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<td>Unemployment Insurance Code</td>
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<td>Evidence Code</td>
<td>Military &amp; Veterans Code</td>
<td>Water Code</td>
</tr>
<tr>
<td>Family Code</td>
<td>Penal Code</td>
<td>Welfare &amp; Institutions Code</td>
</tr>
<tr>
<td>Financial Code</td>
<td>Probate Code</td>
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California’s Managed Care Medicaid & CCR Title 9

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**Regulations = BLUEPRINTS & RULES**
California’s Managed Care Medicaid & CCR Title 9

- California Code of Regulations (blueprints + rules):

[Image of California Code of Regulations website]

Staff Contact: Joseph A Turner, PhD (joe.turner@sfdph.org)
California’s Managed Care Medicaid & CCR Title 9

- **CCR Title 9 = Rehabilitative & Developmental Services**
  - **Division 1 = Department of Mental Health**
    - **Chapter 11 = Medi-Cal Specialty Mental Health Services**
      - **Subchapter 3 = Specialty Mental Health Services Other than Psychiatric Inpatient Hospital Services**

Regulations = BLUEPRINTS & RULES
<table>
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<tr>
<th>Domain</th>
<th>Detail</th>
<th>Document Reference</th>
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<tbody>
<tr>
<td>Medical Necessity (Non-Hospital)</td>
<td>• Medi-Cal criteria (diagnosis, impairments, interventions)</td>
<td>§1830.205 &amp; §1830.210 (p75)</td>
</tr>
<tr>
<td></td>
<td>• EPSDT criteria</td>
<td></td>
</tr>
<tr>
<td>Definitions of Services</td>
<td>• Definition of assessment, plan development, etc.</td>
<td>§1810.204 (p4-)</td>
</tr>
<tr>
<td>Non-Reimbursable Services</td>
<td>• Academic educational services</td>
<td>Subchapter 4, Article 3 (ps 92-93)</td>
</tr>
<tr>
<td></td>
<td>• Vocational services with actual work/training as the purpose</td>
<td></td>
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<tr>
<td></td>
<td>• Recreation</td>
<td></td>
</tr>
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<td></td>
<td>• Socialization without systematic individualized feedback</td>
<td></td>
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<tr>
<td></td>
<td>• Board/care costs of Adult Residential, Crisis Residential, etc.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Services provided in an IMD (21yo-64)</td>
<td></td>
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<td>-------------------------------------------------</td>
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<tr>
<td>Managed Care Duties</td>
<td>• ACCESS: County must have 24/7 accessibility to services</td>
<td>Subchapter 1, Article 4 (ps44-47)</td>
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<tr>
<td></td>
<td>• CULTURE/LANGUAGE: County must have cultural competence plan and</td>
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<td></td>
<td>offer services in threshold languages</td>
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<td></td>
<td>• PROVIDERS: County must have organizational, group and individual</td>
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<td></td>
<td>providers in their network</td>
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<tr>
<td>Quality Management</td>
<td>• QM Director reports to Director of Mental Health Plan</td>
<td>Subchapter 1, Article 4 (ps55-57)</td>
</tr>
<tr>
<td></td>
<td>• QM Program involves providers and consumers</td>
<td></td>
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<td></td>
<td>• QM monitors grievances, appeals and clinical records</td>
<td></td>
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<td></td>
<td>• Maintains Utilization Management program</td>
<td></td>
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<td></td>
<td>• Ensures documentation/medical records are complete (signed by client/provider)</td>
<td></td>
</tr>
<tr>
<td>Federal Financial</td>
<td>• “Claiming” is the process by which MHPs obtain FFP.</td>
<td>Subchapter 4, Article 1 (ps 85-86)</td>
</tr>
<tr>
<td>Participation</td>
<td>• “Reimbursement” means a payment of FFP</td>
<td></td>
</tr>
<tr>
<td>Claiming &amp; Lockouts</td>
<td>• Claiming for services by minutes, hours, days</td>
<td>Subchapter 4, Article 3 (ps 94-108)</td>
</tr>
<tr>
<td></td>
<td>• Service Lockouts (by service)</td>
<td></td>
</tr>
<tr>
<td>Certification of Claims</td>
<td>• Assessment is complete/correct</td>
<td>Subchapter 4, Article 1 (ps 87-88)</td>
</tr>
<tr>
<td>by MHP</td>
<td>• TPOC is complete/correct</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Client was eligible to receive services</td>
<td></td>
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<tr>
<td></td>
<td>• The client actually received the services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Medical necessity for every service was met</td>
<td></td>
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</tbody>
</table>
QA people have a role to play in California’s Managed Care Medicaid Program…

…CCR Title 9, Chapter 11 is your friend!

…let’s teach providers Medical Necessity!
QUESTIONS:

- Do you understand medical necessity as outlined in Title 9?
- Do your clinic staff understand medical necessity as outlined in Title 9?
- Is it possible to have a common understanding of medical necessity?
- Who would benefit if we had a common understanding of medical necessity?
§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 Subsections (1)-(3) below to be eligible for services: (1) Have one of the following diagnoses in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV™, Fourth Edition (1994), 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, except Psychotic Disorders due to a General Medical Condition; (G) Mood Disorders, except Mood Disorders due to a General Medical Condition; (H) Anxiety Disorders, except Anxiety Disorders due to a General Medical Condition; (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) Have at least one of the following impairments as a result of the mental disorder(s) listed in Subsection (b)(1) above: (A) A significant impairment in an important area of life functioning. (B) A reasonable probability of significant deterioration in an important area of life functioning. (C) Except as provided in Section 1830.210, a reasonable probability a child will not progress developmentally as individually appropriate. 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. 4. For a child who meets the criteria of Section 1830.210(1), meet the criteria of Subsection (b)(2) above. (B) The condition would not be responsive to physical health care based treatment. (c) When the requirements of this Section or Section 1830.210 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.

§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 are eligible for EPSDT supplemental specialty mental health services, and who do not meet the medical necessity requirements of Section 1830.205(b)(2)-(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)(A) are met with respect to the mental disorder; 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)(A) with respect to the mental disorder 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 or Section 1830.205 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 and the MHP provides or arranges and pays for such a specialty mental health service. (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, and the MHP provides or arranges and pays for the institutional level of care if the institutional level of care is covered by the MHP under Section 1810.345, or arranges for the institutional level of care, if the institutional level of care is not covered by the MHP under Section 1810.345. For the purpose of this Subsection, the determination of the availability of an appropriate institutional level of care shall be made in accordance with the stipulated settlement in T.L. v. Belshè.

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CDIP View of Medical Necessity:

SFDPH-BHS Clinical Documentation Tools: Medical Necessity Elements & Pathways for Outpatient SMHS

- Included Diagnosis (Element #1)
  - Impairment as a Result of Mental Disorder (Element #2)
    - Pathway #1: Significant impairment in life functioning
      - Significantly diminish the impairment
    - Pathway #2: Probability of significant deterioration in life functioning
      - Prevent significant deterioration in important area of life functioning
    - Pathway #3: Probability child won’t progress developmentally as individually appropriate
      - Allow child to progress developmentally as individually appropriate
    - Pathway #4: *FSMCal < 21: a condition resulting from mental disorder that SMHS can correct or ameliorate
      - *FSMCal = Full Scope Medi-Cal

- Intervention Criteria (Element #3)
- Not Responsive to Physical Health Care (Element #4)

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Easy-Peasy: **Included Diagnosis**

- **Standard interpretation**: if it appears on the list published by DHCS, it’s included

- **Source document**: DHCS MHSUD (Mental Health & Substance Use Disorder Services) Information Notice #15-030 (initial ICD10 crosswalk) and #16-106 (corrected and updated including no diagnosis (Z03.89) and diagnosis deferred (R63))
Easy-Peasy: **Included Diagnosis**

**Standard Charting:**

- **State** the client meets DSM criteria
- **Fully describe symptoms/behaviors** that qualify (onset, frequency, duration, severity, impact)
- **Describe the mechanism** by which symptoms impair the client’s functioning
- All information needed to justify diagnosis is contained in the “Presentation” and “Impact on Functioning” sections of assessment
- **Easy-Peasy: Included Diagnosis**
  - **CCR Title 9 §1830.205:** does not identify specific diagnoses! Only gives the general categories of diagnoses from DSM-IV.

  “…Have one of the following diagnoses in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, Fourth Edition (1994), published by the American Psychiatric Association…”
Easy-Peasy: **Condition not Responsive to Physical Health Care Based Treatment**

- **Standard interpretation:**
  - “**Condition**” = functional impairment (citation = DHCS MHSUDS Information Notice 16-061)
  - “**Not Responsive**” = not improving
  - “**Physical Health Care Based Treatment**” = general health care services focused on physical conditions/diseases
- Tougher: **Pathway #2/Current Significant Impairment-Important Area of Life Functioning**

- **STANDARDIZING** interpretation/charting:

  - **Current** = past 30 days [citation = BHS Memo: Using the CBHS electronic health record (Avatar) to track and maintain Assessment and Treatment Plan of Care (TPOC) timeliness.]

  - “**Impairment**” = the disability caused by the symptoms/behaviors of the diagnosis (citation = MHSUD Info Notice 16-061)
Tougher: Pathway #2/Current Significant Impairment-Important Area of Life Functioning

STANDARDIZING interpretation/charting:

- “Significant” = Important and real (genuine, palpable, practical, noticeable) in its impact to the person

- “Significantly diminish”: (a) diminish: to make or become less; to decrease in size, extent, or range; (b) significant could be objective measures (e.g., 2→1 on the ANSA; clinical→nonclinical status on CBCL)
**Tougher:** Pathway #2/Current Significant Impairment-Important Area of Life Functioning

**Standard interpretation:**

- “Important Area of Life Functioning” = **IS SQUISHY**

**How can we try to understand?**
Sources of Info & Models: Important Area of Life Functioning

1. General Community MH/Systems of Care Logic:
   a) Home Functioning
   b) School/Work Functioning
   c) Community Functioning

   a SAFE strategy!
Sources of Info & Models: Important Area of Life Functioning

2. BHS AVATAR Prompts on Screen-Assessment:
   
   a) **CYF:** Describe impact of the mental health problem on self-care, home, pre-school and community
   
   b) **A/OA:** impact on life/behavior leading to the client to seek services;
Sources of Info & Models: Important Area of Life Functioning

3. BHS CANS/ANSA Items:

a) **CYF 0-4**: Motor, Sensory, Developmental/Intellectual, Communication, Physical/Medical, Family

b) **CYF 5-18**: Family, Living Situation, Recreational, Developmental, Legal, Physical/Medical, Sexuality, School Behavior, School Achievement, School Attendance

c) **A/OA**: Physical/Medical, Family, Recreational, Living Skills, Employment, Transportation, Sexuality, Residential Stability, Legal, Self-Care, Social Functioning, Intellectual
Sources of Info & Models: **Important Area of Life Functioning**

4. **1994 Manual (Rehab Option & Targeted Case Mgmt):**
   
a. **Community Functioning:** (next page) OR
   
b. **Psychiatric Symptoms:** the person exhibits repeated presence of psychotic symptoms OR suicidal ideation or acts OR violent ideation or acts to persons or property. OR
   
c. **Psychiatric History:** the person has a psychiatric history of recurring substantial functional impairment or symptoms. The person's history demonstrates that without mental health service, there is a high risk of recurrence to a level of functional impairment/symptoms listed above.
Sources of Info & Models: Important Area of Life Functioning [1994 Manual (Rehab Option & Targeted Case Mgmt)]:

Community Functioning: reflects the degree in which a mental health illness disrupts or interferes with community living to the extent that without treatment and/or services, the person would be unable to function:

(a) Living arrangements: the person lives in the community in a setting of his/her choice; for children, they live in the home and comply with community rules

(b) Daily Activities: the person is involved in a productive daily activities (may include involvement in household chores, scheduled programs, education and training, and employment; for children, they are involved in age appropriate daily activities (may include involvement in household chores, scheduled programs, education and training, and employment)

(c) Social Relationships: the person demonstrates the ability to establish and maintain relationships and social support systems; for children, they demonstrate the ability to establish and maintain relationships and social support systems; for children, they demonstrate the ability to establish and maintain age appropriate social and family relationships

(d) Health: individual demonstrates the ability to maintain physical and mental hygiene and manage own medications; for children, they experience maximum physical and mental well being, with symptoms minimized and good access to health care services.
Tougher: Pathway #3/Probability of Significant Deterioration in...Life Functioning

STANDARDIZING interpretation/charting:

- **“Probability”** = The extent to which something is probable; the relative likelihood of an event happening or being the case;

- **“Deterioration”** = The process of becoming progressively worse; to make worse; a reduction in ability to perform up to the anticipated standard
Tougher: **Pathway #3/Probability of Significant Deterioration in...Life Functioning**

- **STANDARDIZING interpretation/charting:**
  - "**Significant Deterioration**" = An important and "real" (genuine, palpable, practical, noticeable) worsening/reduction that impacts ability to perform up to the anticipated standard
  - "**Prevent**" = to keep from happening or arising; stop from being in a certain state; to deter or hinder
Teaching Medical Necessity for SMHS:

- **You are SPECIAL** ("specialist vs. generalist")
- **LAWYERS** wrote Title 9 ("flip into pictures & words")
- **FOUR** special components ("not just any old…")
- **FOUR** ways to qualify ("CA’s program is generous")
Teaching Device #1: “Did you know you are special?”

Goals: teach people the technical name for our services + highlight the intense nature of our services

Script:

1. did you know you are special…tell us what makes you special
2. did you know you are special in our system
3. you are special in our system because you provide specialty mental health services
Teaching Device #1: Special

- One way to help people learn is “compare and contrast”

- The opposite of “specialist” is “generalist”

- “General” health care services are provided in health clinics—these are critically important services/staff, but they are generalist services (e.g., diabetes meds)

- “General” mental health services are provided to clients whose impairments are mild/moderate
Teaching Device #1: Special

- Another way to help people learn is to play on their interests (e.g., social justice; advocacy)

- “SMHS are special because they are funded with taxpayer dollars... and taxpayer dollars are very special dollars—they are highly regulated and scrutinized (e.g., you cannot take taxpayer dollars and then discriminate against people)”
Teaching Device #2: “Lawyers wrote Title 9… I flipped it into pictures and words”

Goals: show Title 9 is a regulation and validate difficulty understanding medical necessity, but that you have done the heavy lifting for them.

Script:

1. I’m going to orient you to a document that teaches medical necessity. After I orient you to the document, I’ll explain it to you.
2. Page 1 just shows you the definition from Title 9. Page 2 takes those words and represents them as pictures. Page 3 takes those same words and represents them as a table.
3. Some people learn better from pictures vs. words.
Teaching Device #2: Pictures & Words

The *pictorial representation* helps us understand the relationship between impairments/interventions.

- If client has “current/significant impairments,” then interventions must “significantly reduce impairments.”

The *tabular representation* helps us understand the common elements.

- Every pathway, including EPSDT, *requires an included diagnosis!*
**Teaching Device #3:** “Four special elements in every chart”

- **Goals:** *emphasis on all charts* will have four elements and *encourage staff to look* for those.
Teaching Device #3: FOUR SPECIALS

Script:

1. If you tell me your chart meets medical necessity, then I know I’m going to see 4 special things—follow along on Page 2 of the handout and look at the 4 vertical blue bubbles

2. The first ‘special’ for medical necessity is a special diagnosis…not any old diagnosis, but a special diagnosis

3. The second ‘special’ is a special impairment in functioning…not any old impairment, but a special impairment in functioning

4. The third ‘special’ is the need for special interventions…not any old interventions, but special interventions.

5. The fourth ‘special’ is the need to be served in a specialty setting…not any old physical health care setting
Teaching Device #3: FOUR SPECIALS

- One way to help people learn is the use of repetition.
- Use **rhythm, rhyme and inflection** to help people remember ("...not any old diagnosis, but a...")
Teaching Device #4: “Four Ways to Qualify”

Goals: teach people that there are multiple ways for a client to meet medical necessity; show that maintenance is a valid pathway

Script:

1. Now that we know the 4 common elements, let’s walk though the 4 different ways a client can qualify for medical necessity

2. Look at page 2 of the handout (the picture) and follow along
Teaching Device #4: “Four Ways to Qualify”

Script (continued):

3. Pathway 1 is “current significant impairment in functioning.”
   • This is like your **intake client** who presents with a crisis/problem.
   • Usually clients come to services in some type of **acute state**.
   • You know an acute client **need a service today** because they are having problems.
   • I’m going to refer to this pathway as CURRENT/SIGNIFICANT, ACUTE/INTAKE, and TODAY.
Teaching Device #4: “Four Ways to Qualify”

Script (continued):

- If you argue that your client qualifies through the “current/significant/acute/today” then your progress notes must show that your interventions are significantly reducing the significant impairment!
Teaching Device #4: “Four Ways to Qualify”

Script:

4. Pathway 2 is “risk of significant deterioration.”
   - This is like the client you’ve been seeing for a year who is more stable.
   - Specialty mental health services have been to stabilize/improve the client’s functioning, but yet you know they cannot maintain those gains.
   - We can think about this as your maintenance client—you are trying to help the client maintain their functioning.
   - I will refer to this as “risk of decline,” maintenance and “tomorrow” (i.e., your client is doing ok today, but if you stop providing a service, their functioning will decline TOMORROW.)
**Teaching Device #4: “Four Ways to Qualify”**

**Script (continued):**

- If you argue that your client qualifies through the “risk of significant decline/maintenance/tomorrow” then your progress notes must show that your interventions are preventing significant decline!
Teaching Device #4: “Four Ways to Qualify”

Script:

4. Pathway 3 is confusing and I’ve never seen it in practice
   • A trainer from DHCS explained it like this…
   • A child client has an existing problem that stunts their development (like a developmental delay) and the child’s mental health diagnosis is causing a condition/problem that would further stunt the child’s development
   • As an individual, the child’s developmental problem will limit their development---we do not want that development (which is already stunted) to be further stunted
   • Again, Pathway 3 is a bit confusing.
Teaching Device #4: “Four Ways to Qualify”

Script:

4. Pathway 4 is the EPSDT criteria—again, I have never seen this used in practice, but we can understand this.

- EPSDT is the Medicaid benefit for children
- EPSDT is a federal entitlement for children—it is very broad
- DHCS has clarified that children qualify for SMHS if they have a mild, moderate or significant functional impairment.
- That means that children could receive prevention/early intervention services (for a mild impairment).
- Remember, however, that the child may qualify for a service, but that does not mean that you will provide the service...for an early intervention client, the PPN is the best level of care.
SFDPH-BHS-CDIP Website:

- Not a “buffet” (i.e., take what you want)
- Is “pre fixe” (i.e., the chef gives you)

https://www.sfdph.org/dph/comupg/oservices/mentalHlth/CBHS/CBHSQualityMgmt.asp