BHS Policies and Procedures

City and County of San Francisco
Department of Public Health
San Francisco Health Network
BEHAVIORAL HEALTH SERVICES

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Policy Title: Implementing Non-Hospital/Outpatient Specialty Mental Health Services (SMHS) medical necessity criteria to ensure access to care for Medi-Cal beneficiaries

Issued By: Maximilian Rocha

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Director of Systems of Care

Date: March 25, 2022

Manual Number: 3.04-10

References: DHCS BHIN #: 21-073; California A Welfare & Institutions Code §14184.402. Federal Social Security Act, §1905(r); CFR 42, Chapter IV, Subchapter C, Part 438; CFR 42, § 440.169

Equity Statement: The San Francisco Department of Public Health, Behavioral Health Services (BHS) is committed to leading with race and prioritizing Intersectionality, including sex, gender identity, sexual orientation, age, class, nationality, language, and ability. BHS strives to move forward on the continuum of becoming an anti-racist institution through dismantling racism, building solidarity among racial groups, and working towards becoming a Trauma-Informed/Trauma Healing Organization in partnership with staff, clients, communities, and our contractors. We are committed to ensuring that every policy or procedure, developed and implemented, leads with an equity and anti-racist lens. Our policies will provide the highest quality of care for our diverse clients. We are dedicated to ensuring that our providers are equipped to provide services that are responsive to our client's needs and lived experiences.

Purpose: This policy serves to communicate the current Non-Hospital/Outpatient Specialty Mental Health Services (SMHS) medical necessity definition and criteria for Medi-Cal adult (21 years old and over) and child (under 21 years old) beneficiaries. Additionally, based on the new California Advancing and Innovating Medi-Cal (CalAIM) State Medicaid Contract, this policy also communicates updated information about covered/excluded benefits and activities.

Scope: This policy applies to all providers and provider organizations enrolled in the Mental Health Plan (MHP) and/or contracted to provide Non-Hospital/Outpatient SMHS, including Private Provider Network (PPN), Outpatient, Residential, Crisis Stabilization, Crisis Intervention and Targeted Case Management.

Background: New behavioral health medical necessity definitions and criteria have emerged as a result of reforms in managed care and publicly funded insurance programs like Medicaid. California's new State Medicaid contract and program (CalAIM) includes a new definition and criteria for SMHS medical necessity—these focus on ensuring access to care.

For beneficiaries under 21 years of age, the CalAIM initiative highlights the obligations of all service delivery systems (managed care, behavioral health, fee-for-service) regarding the EPSDT benefit—to provide all Medicaid-coverable services necessary to correct or ameliorate a condition discovered by a screening service, whether or not such services are covered under the State Plan. Furthermore, federal guidance from the Centers for Medicare & Medicaid Services makes it clear that services need not be curative or restorative to ameliorate a condition. Services that sustain, support, improve, or make more tolerable a condition are considered to ameliorate the condition are thus medically necessary and covered as EPSDT services.

Policy: To ensure that Medi-Cal beneficiaries access Non-Hospital/Outpatient SMHS care, it is the policy of BHS that staff obtain and implement the currently published definitions and criteria for medical necessity. The current Non-Hospital/Outpatient SMHS medical necessity definition and criteria for both adult (21 years of age and older) and child (under 21 years of age) beneficiaries is included here as Enclosure 1

DHCS has provided clarification regarding coverage and reimbursement for Non-Hospital/Outpatient SMHS because CalAIM has changed our focus toward "*beneficiary criteria to access services*" and away from "*rigid payment reimbursement/disallowance criteria*." To this end, it is the policy of BHS that Non-Hospital/Outpatient SMHS submitted to BHS comply with the following:

1. Services and activities delivered before a diagnosis is established in the assessment phase, for a suspected mental health disorder: services delivered within the provider's scope of practice and documented appropriately could be provided to a beneficiary prior to determining a diagnosis when the provider has evidence of a suspected mental health disorder (BHIN 21-073, pages 5-6). In these cases, reimbursement can be obtained for included benefits that are clinically appropriate and appropriately delivered and documented.

2. Services and activities delivered but not included on an individual treatment plan: except where federal Medicaid regulations apply (e.g., Targeted Case Management), services and activities which are otherwise appropriately delivered and documented should not be disallowed solely because the service was not included in an individual treatment plan.

3. Services and activities delivered to a beneficiary who has a co-occurring substance use disorder and/or a co-occurring health disorder: there has never been a restriction for beneficiaries who have a primary Mental Health diagnosis and also a secondary co-occurring Substance Use Disorder diagnosis and/or physical health diagnosis.

4. In cases where services are delivered for a suspected mental health disorder, the claim submitted to DHCS must contain a diagnosis code: as a function of DHCS' computer claiming system (Short Doyle/Medi-Cal, SD/MC), every service must include a diagnosis code. For example, these include codes for "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services" (i.e., Z codes).

5. Services for symptoms or conditions solely due to a medical condition are not SMHS benefits: the Managed Care Plans are responsible for this type of benefit (e.g., symptoms or conditions solely due to Traumatic Brain Injury).

6. Services for symptoms or conditions solely due to a substance use disorder condition are not SMHS benefits: the DMC/ODS Plans are responsible for this type of benefit (e.g., symptoms or conditions solely due to substance use disorders).

Contact Person: Director of Systems of Care

Attachment(s):

- Enclosure 1: Behavioral Health Information Notice (BHIN) No: 21-073
- Enclosures 2A – 2B are technical assistance materials that may be useful for education and training (these materials are optional, and providers are not required implement or use these):
    - Enclosure 2A: Medical Necessity Definition & Criteria in Tabular Presentation
    - Enclosure 2B: Managed Care Functions Related to Medical Necessity

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MICHELLE BAASS
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services

GAVIN NEWSOM
GOVERNOR

DATE: December 10, 2021

Behavioral Health Information Notice (BHIN) No: 21-073
Supersedes BHIN 20-043, in part

TO: California Alliance of Child and Family Services
California Association for Alcohol/Drug Educators
California Association of Alcohol & Drug Program Executives, Inc.
California Association of DUI Treatment Programs
California Association of Social Rehabilitation Agencies
California Consortium of Addiction Programs and Professionals
California Council of Community Behavioral Health Agencies
California Hospital Association
California Opioid Maintenance Providers
California State Association of Counties
Coalition of Alcohol and Drug Associations
County Behavioral Health Directors
County Behavioral Health Directors Association of California
County Drug & Alcohol Administrators

SUBJECT: Criteria for beneficiary access to Specialty Mental Health Services (SMHS), medical necessity and other coverage requirements

PURPOSE: To give notice of statutory changes for a beneficiary to access the SMHS delivery system and update medical necessity and coverage requirements.

REFERENCES: Welfare and Institutions Code section 14184.402

BACKGROUND:

With the California Advancing and Innovating Medi-Cal (CalAIM) initiative, the Department of Health Care Services (DHCS) aims to design a coherent plan to address beneficiaries' needs across the continuum of care, ensure that all Medi-Cal beneficiaries receive coordinated services, and improve health outcomes. The goal is to ensure access to the right care in the right place at the right time.

To achieve this aim, DHCS is clarifying the responsibilities of Mental Health Plans (MHPs), including updating the criteria for access to SMHS, for both adults and beneficiaries under age 21, except for psychiatric inpatient hospital and psychiatric health facility services, which will be addressed in forthcoming guidance. These criteria were developed based on significant feedback from stakeholders.

Assembly Bill (AB) 133 implements various components of the CalAIM initiative. As specified in Welfare and Institutions Code section 14184.402, the revised definitions and criteria below are effective January 1, 2022. AB 133 gives DHCS authority to implement the criteria for access to SMHS and medical necessity through this Behavioral Health Information Notice (BHIN) until DHCS implements new regulations by July 1, 2024.

Effective January 1, 2022, the definition of medical necessity and the criteria for access to SMHS (except for psychiatric inpatient hospital and psychiatric health facility services, which will be addressed in forthcoming guidance) is as established below.

This BHIN supersedes California Code of Regulations (CCR), title 9, sections 1830.205 and 1830.210[1] and other guidance published prior to January 1, 2022 regarding medical necessity criteria for MHP reimbursement of SMHS (other than psychiatric inpatient hospital and psychiatric health facility services), including components of BHIN 20-043. This BHIN does not address or supersede criteria for psychiatric inpatient hospital and psychiatric health facility services, which will be addressed in forthcoming guidance.

POLICY:

Medical Necessity

Pursuant to Welfare and Institutions Code section 14184.402(a), for individuals 21 years of age or older, a service is “medically necessary” or a “medical necessity” when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain as set forth in Welfare and Institutions Code section 14059.5.

For individuals under 21 years of age, a service is “medically necessary” or a “medical necessity” if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code. This section requires provision of all Medicaid-coverable services necessary to correct or ameliorate a mental illness or condition discovered by a

[1] The CCR medical necessity regulations superseded by this BHIN combine criteria for access to SMHS and medical necessity for specific services. Under this BHIN, access criteria and medical necessity criteria are separated and redefined.

screening service, whether or not such services are covered under the State Plan. Furthermore, federal guidance from the Centers for Medicare & Medicaid Services makes it clear that mental health services need not be curative or restorative to ameliorate a mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition are thus medically necessary and covered as EPSDT services.

Services provided to a beneficiary must be medically necessary and clinically appropriate to address the beneficiary's presenting condition.[2]

Criteria for Adult Beneficiaries to Access the Specialty Mental Health Services Delivery System

For beneficiaries 21 years of age or older, a county mental health plan shall provide covered specialty mental health services for beneficiaries who meet **both of the following** criteria, (1) and (2) below:

(1) The beneficiary has **one or both** of the following:
   a. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities.

   b. A reasonable probability of significant deterioration in an important area of life functioning.

AND

(2) The beneficiary's condition as described in paragraph (1) is due to **either of the following**:
   a. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders[3] and the International Statistical Classification of Diseases and Related Health Problems.

   b. A suspected mental disorder that has not yet been diagnosed.

[2] 42 C.F.R. §§ 456.5 and 440.230 (b)
[3] A neurocognitive disorder (e.g., dementia) or a substance-related and addictive disorder (e.g., stimulant use disorder) are not "mental health disorders" for the purpose of determining whether a beneficiary meets criteria for access to the SMHS delivery system. However, MHPs must cover SMHS for beneficiaries with any of these disorders if they also have a mental health disorder (or suspected mental health disorder not yet diagnosed) and meet criteria for SMHS as described above.

Criteria for Beneficiaries under Age 21 to Access the Specialty Mental Health Services Delivery System

For enrolled beneficiaries under 21 years of age, a county mental health plan shall provide all medically necessary specialty mental health services required pursuant to Section 1396d(r) of Title 42 of the United States Code. Covered specialty mental health services shall be provided to enrolled beneficiaries who meet **either of the following** criteria, (1) or (2) below:

(1) The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by the department[4], involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness.[5]

OR

(2) The beneficiary meets **both of the following** requirements in a) and b), below:
   a) The beneficiary has **at least one** of the following:
      i. A significant impairment

      ii. A reasonable probability of significant deterioration in an important area of life functioning

      iii. A reasonable probability of not progressing developmentally as appropriate.

      iv. A need for specialty mental health services, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide.

[4] The Pediatric ACES and Related Life-Events Screener (PEARLS) tool is one example of a standard way of measuring trauma for children and adolescents through age 19. The ACE Questionnaire is one example of a standard way of measuring trauma for adults beginning at age 18. DHCS will explore the approval process and standards for trauma screening tools for beneficiaries under 21 years of age through continued stakeholder engagement. MHPs are not required to implement the tool until DHCS issues additional guidance regarding approved trauma screening tool(s) for the purposes of SMHS access criteria.

[5] Please see Definitions section below for additional information.

AND

b) The beneficiary's condition as described in subparagraph (2) above is due to **one of the following**:
   i. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders[6] and the International Statistical Classification of Diseases and Related Health Problems.

   ii. A suspected mental health disorder that has not yet been diagnosed.

   iii. Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.[7]

If a beneficiary under age 21 meets the criteria as described in (1) above, the beneficiary meets criteria to access SMHS; it is not necessary to establish that the beneficiary also meets the criteria in (2) above.

Additional Coverage Requirements and Clarifications

This criteria for a beneficiary to access the SMHS delivery system (except for psychiatric inpatient hospital and psychiatric health facility services) set forth above shall not be construed to exclude coverage for, or reimbursement of, a clinically appropriate and covered mental health prevention, screening, assessment, treatment, or recovery service under any of the following circumstances:

- Services were provided prior to determining a diagnosis, including clinically appropriate and covered services provided during the assessment process.
- The prevention, screening, assessment, treatment, or recovery service was not included in an individual treatment plan.[8]
- The beneficiary has a co-occurring substance use disorder.

[6] A neurocognitive disorder (e.g., dementia) or a substance-related and addictive disorder (e.g., stimulant use disorder) are not "mental health disorders" for the purpose of determining whether a beneficiary meets criteria for access to the SMHS delivery system. However, MHPs must cover SMHS for beneficiaries with any of these disorders if they also have a mental health disorder (or suspected mental health disorders not yet diagnosed) and meet criteria for SMHS as described above.
[7] Welf. & Inst. Code, § 14184.402(d)
[8] Some SMHS may still require an individual plan of care, such as Targeted Case Management (42 C.F.R. § 440.169.). DHCS will issue forthcoming guidance regarding documentation requirements.

Per Welfare and Institutions Code section 14184.402(f)(1)(A), a mental health diagnosis is not a prerequisite for access to covered SMHS. This does not eliminate the requirement that all Medi-Cal claims, including SMHS claims, include a CMS approved ICD-10 diagnosis code.[9] In cases where services are provided due to a suspected mental health disorder that has not yet been diagnosed or due to trauma as noted above, options are available in the CMS approved ICD-10 diagnosis code list. For example, these include codes for "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services" (i.e., Z codes). DHCS may provide additional clarification and technical assistance regarding the use of Z codes.

The portion of BHIN 20-043 that limits SMHS to a list of DHCS included ICD-10 diagnoses is superseded by this BHIN, effective January 1, 2022, except for psychiatric inpatient hospital and psychiatric health facility services, which will be addressed in forthcoming guidance.

This BHIN does not change the respective responsibilities of MHPs, Medi-Cal Managed Care Plans (MCPs) and the Medi-Cal Fee for Service (FFS) delivery systems. Services for symptoms or conditions solely due to a medical condition (e.g., traumatic brain injury) remain the responsibility of the MCP or the FFS delivery system. However, SMHS are reimbursable for beneficiaries with medical diagnoses if they also have mental health conditions and meet criteria for SMHS as described above.

Non-specialty mental health services (NSMHS) are delivered by Medi-Cal FFS providers and MCPs and include the following:[10]

- Mental health evaluation and treatment, including individual, group and family psychotherapy[11]
- Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.
- Outpatient services for purposes of monitoring drug therapy
- Psychiatric consultation
- Outpatient laboratory, drugs, supplies and supplements

[9] The ICD 10 Tabular (October 1st thru September 30th) at https://www.cms.gov/medicare/icd-10/2022-icd-10-cm
[10] Welf. & Inst. Code, § 14184.402(b)(1)
[11] Dyadic services will be provided effective 7/1/22.

Criteria for Beneficiaries to Access Non-Specialty Mental Health Services

MCPs are required to provide or arrange for the provision of NSMHS for the following populations:[12]

- Beneficiaries 21 years of age and over with mild to moderate distress or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders;[13]
- Beneficiaries under age 21, to the extent eligible for services through the Medicaid EPSDT benefit as described above, regardless of level of distress or impairment or the presence of a diagnosis;
- Beneficiaries of any age with potential mental health disorders not yet diagnosed.

DHCS will publish additional guidance regarding the CalAIM No Wrong Door policies for mental health services in Medi-Cal as set forth in Welfare and Institutions Code 14184.402.

COMPLIANCE:

MHPs shall implement the criteria for access to SMHS established above effective January 1, 2022, update MHPs policies and procedures as needed to ensure compliance with this policy effective January 1, 2022, and communicate these updates to providers as necessary.[14]

In addition, MHPs shall update materials to ensure the criteria for SMHS for individuals under 21 years of age and for adults is accurately reflected, including materials reflecting the responsibility of Medi-Cal MCPs and the FFS delivery system for covering NSMHS.

[12] Welf. & Inst. Code, § 14184.402(b)(2)
[13] A neurocognitive disorder (e.g., dementia) or a substance-related and addictive disorder (e.g., stimulant use disorder) are not “mental health disorders” for the purpose of determining whether a beneficiary meets criteria for access to the NSMHS delivery system. However, MCPs must cover NSMHS for beneficiaries with any of these disorders if they also have a mental health disorder (or suspected mental health disorders not yet diagnosed) and meet criteria for NSMHS as described above.
[14] Welf. & Inst. Code, § 14184.402(i)

DEFINITIONS:

Involvement in child welfare: The beneficiary has an open child welfare services case, or the beneficiary is determined by a child welfare services agency to be at imminent risk of entering foster care but able to safely remain in their home or kinship placement with the provision of services under a prevention plan, or the beneficiary is a child whose adoption or guardianship occurred through the child welfare system. A child has an open child welfare services case if: a) the child is in foster care or in out of home care, including both court-ordered and by voluntary agreement; or b) the child has a family maintenance case (pre-placement or post-reunification), including both court-ordered and by voluntary agreement. A child can have involvement in child welfare whether the child remains in the home or is placed out of the home.

Homelessness: The beneficiary meets the definition established in section 11434a of the federal McKinney-Vento Homeless Assistance Act.[15] Specifically, this includes (A) individuals who lack a fixed, regular, and adequate nighttime residence (within the meaning of section 103(a)(1) of the Act); and (B) includes (i) children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; or are abandoned in hospitals; (ii) children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (within the meaning of section 103(a)(2)(C)); (iii) children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and (iv) migratory children (as such term is defined in section 1309 of the Elementary and Secondary Education Act of 1965) who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses (i) through (iii).

Juvenile justice involvement: The beneficiary (1) has ever been detained or committed to a juvenile justice facility, or (2) is currently under supervision by the juvenile delinquency court and/or a juvenile probation agency. Beneficiaries who have ever been in custody and held involuntarily through operation of law enforcement authorities in a juvenile justice facility, including youth correctional institutions, juvenile detention facilities, juvenile justice centers, and other settings such as boot camps, ranches, and forestry/conservation camps, are included in the "juvenile justice involvement" definition. Beneficiaries on probation, who have been released home or

[15] Available at: https://nche.ed.gov/mckinney-vento-definition/. Full text of the Act is available here: http://uscode.house.gov/view.xhtml?path=/prelim@title42/chapter119/subchapter6/partB&edition=prelim.

detained/placed in foster care pending or post-adjudication, under probation or court supervision, participating in juvenile drug court or other diversion programs, and who are otherwise under supervision by the juvenile delinquency court and/or a juvenile probation agency also meet the “juvenile justice involvement” criteria.

Please direct any questions to countysupport@dhcs.ca.gov

Sincerely,

Original signed by

Shaina Zurlin, LCSW, PsyD, Chief
Medi-Cal Behavioral Health

Enclosure 2A: Tabular Presentation Non-Hospital Adult (21 years and older) SMHS Medical Necessity Criteria

	MEETS BOTH OF THE FOLLOWING CRITERIA 1 AND 2 BELOW:			
	The beneficiary has one or both of the following:		**Condition is due to one of the following:**	
	Criteria 1a	**Criteria 1b**	**Criteria 2a**	**Criteria 2b**
NON-HOSPITAL SMHS ADULTS *For beneficiaries aged 21 years old and above, "Medical Necessity" means Pursuant to Welfare and Institutions Code section 14184.402(a), for individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain as set forth in W&I Code section 14059.5.*	***Significant impairment***, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities.	A reasonable ***probability of significant deterioration*** in an important area of life functioning.	***A diagnosed mental health disorder***, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	A ***suspected*** mental disorder that has ***not yet been diagnosed***
*Algorithm: **BOTH** [one or both of 1a/1b] **AND** [one of 2a/2b]*				

Enclosure 2A: Tabular Presentation Non-Hospital Child (under 21 years) SMHS Medical Necessity Criteria

NON-HOSPITAL SMHS UNDER 21 YEARS (CHILD/YOUTH)	**MEETS EITHER CRITERIA 1 OR CRITERIA 2**		
	Criteria 1	**Criteria 2**	
		The beneficiary meets both of the following requirements in 2a and 2b:	
		Criteria 2a: *At least one* of the following	**Criteria 2b: The condition is *due to one* of the following**
For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code. This section requires provision of all Medicaid-coverable services necessary to correct or ameliorate a mental illness or condition discovered by a screening service, whether or not such services are covered under the State Plan. Furthermore, federal guidance from the Centers for Medicare & Medicaid Services makes it clear that mental health services need not be curative or restorative to ameliorate a mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition are thus medically necessary and covered as EPSDT services. Services provided to a beneficiary must be medically necessary and clinically appropriate to address the beneficiary's presenting condition	The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by the department4, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness	• A ***significant*** impairment ***AND/OR*** • A ***reasonable probability of significant deterioration*** in an important area of life functioning ***AND/OR*** • A reasonable probability of ***not progressing developmentally*** as appropriate. ***AND/OR*** • A need for specialty mental health services, ***regardless of presence of impairment, that are not included within the mental health benefits*** that a Medi-Cal managed care plan is required to provide.	• A ***diagnosed mental health disorder***, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders6 and the International Statistical Classification of Diseases and Related Health Problems. ***OR*** • A suspected mental health disorder that has ***not yet been diagnosed***. ***OR*** • ***Significant trauma placing the beneficiary at risk of a future*** mental health condition, based on the assessment of a licensed mental health professional
*Algorithm: **EITHER** [Criteria 1] **OR** [both of 2a/2b]*			

Enclosure 2A: Tabular Presentation Inpatient Psychiatric Hospital and Psychiatric Health Facility (PHF) SMHS Medical Necessity for Admission and Continued Stay Criteria

<table>
<tr><td rowspan="3"><u>ADMISSION</u> - PSYCHIATRIC INPATIENT HOSPITAL AND PSYCHIATRIC HEALTH FACILITY SERVICES</td><td colspan="3">MEETS ALL (CRITERIA 1 AND CRITERIA 2 AND CRITERIA 3)</td></tr>
<tr><td>Criteria 1</td><td>Criteria 2</td><td>Criteria 3</td></tr>
<tr><td>The beneficiary has mental health or substance use-induced mental health symptom(s) and/or behavior(s) that meet one of the following criteria</td><td>Psychiatric Inpatient Services or PHF services are required to ensure the beneficiary can receive <u>one or more</u> of the following:</td></tr>
<tr><td>The beneficiary cannot be safely and effectively treated at a lower level of care</td><td>• Pose danger to self or others;

OR

• Prevent the beneficiary from appropriately utilizing food, clothing, or shelter;

OR

• Pose a significant health risk or potential loss of life;

OR

• Pose a severe risk of significant deterioration in life functioning that would result in exacerbation of the psychiatric illness to a degree that would necessitate hospitalization.</td><td>Further assessment or specialty mental health service necessary for acute psychiatric stabilization;

AND/OR

• Medication support services;

AND/OR

• Other specialty mental health services that can reasonably be provided only if the beneficiary is hospitalized.</td></tr>
<tr><td colspan="4">Algorithm: ALL OF [Criteria 1] AND [Criteria 2] AND [Criteria 3]</td></tr>
</table>

	MEETS ALL (CRITERIA 1 AND CRITERIA 2)	
	Criteria 1	**Criteria 2**
	The treating clinician(s) continues to ***identify the symptoms or behaviors in admission criteria as follows***	Psychiatric inpatient services or PHF services continue to be required ***to address any of the following***:
<u>CONTINUED STAY</u> - PSYCHIATRIC INPATIENT HOSPITAL AND PSYCHIATRIC HEALTH FACILITY SERVICES	• Pose danger to self or others; ***OR*** • Prevent the beneficiary from appropriately utilizing food, clothing, or shelter; ***OR*** • Pose a significant health risk or potential loss of life; ***OR*** • Pose a severe risk of significant deterioration in life functioning that would result in exacerbation of the psychiatric illness to a degree that would necessitate hospitalization.	• serious adverse medication reactions ***OR*** • need for continued psychiatric evaluation and specialty mental health services, ***OR*** • thepresence of a new risk to psychiatric stability
Algorithm: ***BOTH*** *[Criteria 1]* ***AND*** *[Criteria 2]*		

Purpose: this document is designed to provide technical assistance to providers as they consider and implement the Non-Hospital/Outpatient SMHS Medical Necessity definition and criteria (effective 01/01/2022, per BHIN#21-073, as part of CalAIM). Specifically, this document identifies a range of managed care functions that relate to medical necessity.

Managed Care Functions Related to Medical Necessity: This list is intended to stimulate thought about implementation planning and workflow development (vs. being exhaustive or comprehensive)

- Verifying client's identity, eligibility for Medi-Cal benefits and any other health insurance coverage: before attempting to establish medical necessity, providers must verify the client's identity, verify the client's current eligibility for Medi-Cal benefits and also document any other insurance coverage information (e.g., Medicare);

- Beneficiary rights, grievances and appeals: in circumstances where a client does not meet medical necessity, providers inform the clients of their rights (e.g., reminding client of the right to request a "second opinion");

- Utilization Management, Utilization Review and Utilization Control (UM, UR, and UC, respectively): in circumstances where a payment authorization request is denied due to medical necessity not being met, the UM/UR/UC program informs the client of their rights (e.g., Notice of Adverse Benefit Determination, NOABD) and the provider of their rights (i.e., the right to have the determination reviewed by another UM staff);

- Coordination across delivery systems: in circumstances where a client does not meet medical necessity for SMHS, we utilize the appropriate resources to link the client to the correct delivery system:

    - *ODS/DMC*: Services for symptoms or conditions solely due to a substance use disorder condition are provided by the ODS/DMC system

    - *Managed Care Plans (MCP)*: (1) Services for symptoms or conditions solely due to a medical condition are provided by the MCP; (2) Services for mild-to-moderate behavioral health conditions are provided by the MCP