INLAND EMPIRE HEALTH PLAN

MMCD Letter No. 96-07
July 5, 1996

WHAT ARE EPSDT SUPPLEMENTAL SERVICES?

EPSDT Supplemental Services are those medically-necessary services that are available to the Medi-Cal population under age 21. There are three ways in which EPSDT supplemental services may be determined medically necessary:

1. The requested EPSDT supplemental services can meet the existing criteria for medical necessity applicable to services that are available to the general Medi-Cal population; or

2. The requested EPSDT supplemental services can meet distinct, EPSDT service specific requirements.

3. If the criteria of number one cannot be met, and if the criteria of number two above are not applicable to the service, then the requested EPSDT supplemental services must be evaluated under the expanded medical necessity criteria established in the EPSDT regulations in Title 22, CCR, Section 51340(e)(3), as summarized below:

    - The services are to correct or ameliorate defects or physical and mental illnesses or conditions discovered by the screening services.

    - The supplies, items, or equipment to be provided are medical in nature.

    - The services are not requested solely for the convenience of the Member, family, physician, or other provider of services.

    - The services are not primarily cosmetic in nature or primarily to improve the Member's appearance.

    - The services are safe and not experimental and are recognized as an accepted modality of medical practice.

    - Where alternative medically accepted modes of treatment are available, the EPSDT supplemental services are the most cost effective. The plan may determine the most cost-effectiveness setting for services on a case-by-case basis. Where the determination of cost-effectiveness involves an assessment of services not covered by the plan (e.g., home- and community-based waiver services or long-term care in a

nursing facility), the plan must coordinate the determination of cost-effectiveness with DHCS.

- The services to be provided are generally recognized as an accepted modality of medical practice or treatment, are within the authorized scope of practice of the provider, and are an appropriate mode of treatment for the medical condition of the beneficiary.

- There is scientific evidence, consisting of well-designed and conducted investigations published in peer-review journals, demonstrating that the service can be produce measurable physiological alterations beneficial to health outcomes, or in the case of psychological or psychiatric services measurable psychological outcomes concerning the short- and long-term effects of the proposed services. Opinions and evaluations published by national medical organizations, consensus panels, and other technology-evaluation bodies supporting provision of the benefit shall also be considered when available.

- The predicted beneficial outcome of the service outweighs potential harmful effects.

- The services improve the overall health outcomes as much as, or more than, established alternatives.

Examples of EPSDT supplemental services are cochlear implants. EPSDT case management services, and EPSDT supplemental nursing services. EPSDT case management services and EPSDT supplemental nursing services are discussed in more detail below.

EPSDT SUPPLEMENTAL NURSING SERVICES

EPSDT supplemental nursing services mean hourly or shift nursing services provided by or under the supervision of licensed, skilled nursing personnel in a Member's residence or in a specialized foster care home. EPSDT supplemental nursing services are covered when they meet the medical-necessity criteria in Section 51340(e) and the following conditions are met:

- The Member for whom nursing care is requested meets any of the criteria for admission to licensed and certified health facility inpatient care settings, and his/her medical condition has stabilized such that care can safely be rendered in the home; or

The Member is newly discharged from an acute or subacute inpatient setting and is dependent upon a life-sustaining medical technology, and his/her medical condition has stabilized such that care can safely be rendered in the home.

- The nursing services are provided by licensed, skilled nursing personnel with experience and training appropriate to the needs of the Member for whom the services are to be provided.

- There is a primary caregiver in the home that is proficient in the tasks necessary to care for the Member.

- An assessment of the home environment has been conducted by a qualified home health agency or other appropriate persons. The assessment must verify that an attending physician accepts twenty-four hour responsibility for providing and coordinating medical care; the home environment supports the health and safety of the beneficiary; that space is adequate to accommodate needed equipment, supplies, and personnel; that the family caregivers have been appropriately trained; and that all necessary supports and an emergency back-up plan are in place. This assessment is the responsibility of the plan, but may be subject to prior authorization consistent with the Member meeting other criteria for EPSDT supplemental nursing services.

EPSDT supplemental nursing services should be provided at home or in an appropriate facility consistent with Title 22, CCR, Section 51340(m).

DHCS

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: March 2, 2018

ALL PLAN LETTER 18-007
SUPERSEDES ALL PLAN LETTER 14-017

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: REQUIREMENTS FOR COVERAGE OF EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICES FOR MEDI-CAL MEMBERS UNDER THE AGE OF 21

PURPOSE:
This All Plan Letter (APL) clarifies the responsibilities of Medi-Cal managed care health plans (MCPs) to provide Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to eligible members under the age of 21. This policy applies to all members under the age of 21 enrolled in MCPs. This guidance is intended to reinforce existing state and federal laws and regulations regarding the provision of Medi-Cal services, including EPSDT, and does not represent any change in policy. This APL supersedes APL 14-017.

BACKGROUND:
In 1967, Congress expanded the EPSDT benefit for children. The EPSDT benefit provides comprehensive screening, diagnostic, treatment, and preventive health care services for individuals under the age of 21 who are enrolled in Medi-Cal and is key to ensuring that members who are eligible for EPSDT services receive appropriate preventive, dental, mental health, developmental, and specialty services.

Section 1905(r) of the Social Security Act (SSA) defines the EPSDT benefit to include a comprehensive array of preventive, diagnostic, and treatment services for low-income individuals under 21 years of age.[1] States are required to provide any Medicaid covered services listed in section 1905(a) of the SSA for members who are eligible for EPSDT services when the services are determined to be medically necessary to correct or ameliorate any physical or behavioral conditions. In accordance with Title 42 of the Code of Federal Regulations (CFR), Section 440.130(c), services must also be provided when medically necessary to prevent disease, disability, and other health conditions or their progression, to prolong life, and to promote physical and mental health and efficiency.[2] The EPSDT benefit is more robust than the Medi-Cal benefit

[1] Section 1905 of the SSA is available at: https://www.ssa.gov/OP_Home/ssact/title19/1905.htm
[2] 42 CFR, Part 440, is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=9568043f8b1386fd23340e60c3e9da4f&mc=true&node=pt42.4.440&rgn=div5

package provided to adults and is designed to ensure that eligible members receive early detection and preventive care in addition to medically necessary treatment services, so that health problems are averted or diagnosed and treated as early as possible.

Title 42 of the United States Code (USC), Section 1396d(r), defines EPSDT services as including the following:[3, 4]

1) Screening services provided at intervals which meet reasonable standards of medical and dental practice and at other intervals indicated as medically necessary to determine the existence of physical or mental illnesses or conditions. Screening services must include, at a minimum, a comprehensive health and developmental history (including assessment of both physical and mental health development); a comprehensive unclothed physical exam; appropriate immunizations; laboratory tests (including blood lead level assessment appropriate for age and risk factors); and health education (including anticipatory guidance).

2) Vision services provided at intervals which meet reasonable standards of medical practice and at other intervals indicated as medically necessary to determine the existence of a suspected illness or condition. Vision services must include, at a minimum, diagnosis and treatment for defects in vision, including eyeglasses.

3) Dental services provided at intervals which meet reasonable standards of dental practice and at other intervals indicated as medically necessary to determine the existence of a suspected illness or condition. Dental services must include, at a minimum, treatment for relief of pain and infections, restoration of teeth, and maintenance of dental health.

4) Hearing services provided at intervals which meet reasonable standards of medical practice and at other intervals indicated as medically necessary to determine the existence of a suspected illness or condition. Hearing services must include, at a minimum, diagnosis and treatment for defects in hearing, including hearing aids.

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[3] 42 USC, Section 1396d, is available at: http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section1396d&num=0&edition=prelim

[4] The Patient Protection and Affordable Care Act (ACA) mandated the use of the current American Academy of Pediatrics "Bright Futures" periodicity schedule and guidelines when delivering the EPSDT benefit, including, but not limited to, screening services, vision services, and hearing services. MCPs must also provide all age-specific assessments and services required by the MCP contract.

5) Other necessary health care, diagnostic services, treatment, and measures, as described in 42 USC 1396d(a), to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services or items are listed in the state plan or are covered for adults.

The California Code of Regulations (CCR) further clarifies the parameters of California's implementation of the EPSDT program.[5] Pursuant to Title 22 of the CCR, Section 51184(a)(3), screening services include any other encounter with a licensed health care provider that results in the determination of the existence of a suspected illness or condition or a change or complication in a condition. Screening services must identify developmental issues as early as possible.

EPSDT in California

MCPs are required to provide and cover all medically necessary services. For members age 21 and over, medically necessary services include all covered services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury. For members under age 21, MCPs must provide a broader range of medically necessary services that is expanded to include standards set forth in federal law and the CCRs.

The EPSDT benefit in California is set forth under Title 22, CCR, Sections 51340, 51340.1, and 51184. It includes all medically necessary services as described under Title 22, CCR, Section 51184, and Title 9, CCR, Sections 1820.205 and 1830.210 that may be referred to as "EPSDT Supplemental Services" in the MCP contract with the Department of Health Care Services (DHCS).

MCPs' Contractual Requirements

MCPs are required to cover and ensure the provision of screening, preventive, and medically necessary diagnostic and treatment services for members under the age of 21, including EPSDT Supplemental Services. The EPSDT benefit includes case management and targeted case management services designed to assist members in gaining access to necessary medical, social, educational, and other services.

MCPs must ensure that comprehensive case management is provided to each member. MCPs must maintain procedures for monitoring the coordination of care provided to members, including but not limited to all medically necessary services delivered both within and outside the MCP's provider network. If the MCP determines that case

[5] The CCR is searchable by Title and Section at: https://govt.westlaw.com/calregs/Search/Index

management services are medically necessary and not otherwise available, the MCP shall provide, or arrange and pay for, the case management services for its members who are eligible for EPSDT services (Title 22, CCR, Section 51340(k)).

For example, while services provided by the California Children's Services (CCS) program are not covered under most MCP contracts with DHCS, upon adequate diagnostic evidence that a member has a CCS-eligible condition, MCPs must refer the member to the local county CCS office for determination of eligibility. If the local CCS program does not approve eligibility, the MCP remains responsible for the provision of all medically necessary covered services for the member. If CCS denies a particular medically necessary service, MCPs may provide services through providers within the MCPs' network. If the local CCS program denies authorization for any service, the MCP remains responsible for providing the medically necessary service as determined by the MCP provider.

In addition, MCPs are also required to establish procedures for members to obtain necessary transportation services, including medical and non-medical transportation services. For additional transportation guidance, please refer to APL 17-010, Non-Emergency Medical and Non-Medical Transportation Services.[6]

Dental services are carved-out of the MCP contract with DHCS. MCPs must cover and ensure that dental screenings for all members are included as a part of the initial health assessment. For members under the age of 21, a dental screening/oral health assessment must be performed as part of every periodic assessment. MCPs must ensure that members are referred to appropriate Medi-Cal dental providers. MCPs must cover and ensure the provision of covered medical services related to dental services that are not provided by dentists or dental anesthetists, but may require prior authorization for medical services required in support of dental procedures.

All members under the age of 21 must receive EPSDT screenings designed to identify health and developmental issues, as early as possible. The EPSDT benefit also includes medically necessary diagnostic and treatment services for members with developmental issues, when a screening examination indicates the need for further evaluation of a child's health. The member should be appropriately referred for diagnosis and treatment without delay. MCPs are responsible for providing medically necessary Behavioral Health Treatment (BHT) services for members that meet eligibility criteria for services outlined in section 1905(a) of the SSA. For more information on MCP requirements on the provision of BHT services to eligible members, please refer to the APL 18-006, *Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21.*

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[6] DHCS All Plan Letters are available at: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

MCPs must ensure that the criteria set forth in Title 22, CCR, Section 51340.1 are met when approving the following EPSDT services: hearing services, onsite investigations to detect the source of lead contamination, and pediatric day health care services.

In addition, MCPs must comply with the Americans with Disabilities Act mandate to provide services in the most integrated setting appropriate to members (*Olmstead v. L.C. ex rel. Zimring* (1999) 527 U.S. 581), and with California Government Code (GOV) Section 11135.[7]

POLICY:
Where diagnostic, treatment or other EPSDT services are provided in a home or community-based setting, the total costs incurred by the Medi-Cal program for the service must be less than what the total costs would be for the provision of "medically equivalent services" in an appropriate institutional level of care (Title 22, CCR, Section 51340(m)). "Medically equivalent services" includes services to address developmental needs that otherwise would be addressed in the home or other community setting. Pursuant to Title 22, CCR, Section 51340, speech therapy, occupational therapy, and physical therapy services are exempt from the benefit limitations set forth under Title 22, CCR, Section 51304. MCPs may not impose service limitations. In addition, MCPs are required to provide speech therapy, occupational therapy, and physical therapy services when medically necessary to correct or ameliorate defects discovered by screening services, whether or not such services or items are covered under the state plan unless otherwise specified in the applicable MCP contract with DHCS.

MCPs are required to provide appointment scheduling assistance and necessary transportation, including non-emergency medical transportation and non-medical transportation, to and from medical appointments for the medically necessary services that MCPs are responsible for providing pursuant to their contracts with DHCS.

MCPs must ensure that members under the age of 21 who are eligible for EPSDT services and their parents or guardians know what services are available and have access to the health care resources they need. MCPs have a responsibility to provide health education, including anticipatory guidance, to members under age 21 and to their parents or guardians in order to effectively use those resources, including screenings and treatment (Title 42, US Code, Section 1396d(r)(1)(B)(v); Centers for Medicare & Medicaid Services, *EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents*, p. 4)).

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[7] See GOV Section 11135 at:
http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=11135.&lawCode=GOV

Specifically, for members under the age of 21, MCPs are required to provide and cover all medically necessary services **with the following exceptions**:

A. Dental services provided by dental personnel covered by the Medi-Cal Denti-Cal program (Policy Letter 13-002);

B. Non-medical services provided by Regional Centers (RCs) to members with developmental disabilities, including, but not limited to, respite, out-of-home placement, and supportive living. However, MCPs must monitor and coordinate all medical services with RC staff;

C. Alcohol and substance use disorder treatment services available under the Drug Medi-Cal Program and outpatient heroin detoxification services, including all medications used for treatment of alcohol and substance use disorder covered by DHCS, as well as specific medications not currently covered by DHCS, but reimbursed through Medi-Cal fee-for-service (FFS);

D. Specialty mental health services listed in Title 9, CCR, Section 1810.247 for members that meet medical necessity criteria as specified in Title 9, CCR, Sections 1820.205, 1830.205, or 1830.210, which must be provided by a mental health plan (APLs 13-018 and 17-018);

E. CCS services not included in the MCP capitated rate. The EPSDT services determined to be medically necessary for treatment or amelioration of the CCS-covered condition, including private duty nursing related to a CCS-eligible condition, must be case managed and have obtained prior authorization by the CCS program (on a FFS basis) (Title 22, CCR, Section 51013);[8]

F. Services for which prior authorization is required but are provided without obtaining prior authorization; and

[8] For members enrolled in an MCP and who have been referred to the CCS program for case management and authorization of nursing services, the provider will submit the private duty nursing Treatment Authorization Request (TAR) to the EPSDT unit of the DHCS Integrated Systems of Care Division. The EPSDT unit will verify with the local CCS County program that the child is enrolled in the CCS program and the nursing services are related to the CCS-eligible medical condition. If the member is deemed to have a CCS-eligible medical condition, the EPSDT unit will review the TAR for medical necessity for the requested nursing services. The EPSDT unit will then refer the TAR to the local CCS program and will recommend authorization of services. If the member is not enrolled in the CCS program or the nursing services are not related to the CCS-eligible medical condition, the EPSDT unit will defer the TAR back to the provider to submit the request and or claims to the MCP pursuant to 22 CCR Sections 51003(c) and 51014.1(e).

G. Other services listed as services that are not "Covered Services" under the MCP contract with DHCS, such as Pediatric Day Health Care services.

Where another entity—such as a local education agency (LEA), RC, or local governmental health program—has overlapping responsibility for providing services to a member under the age of 21, MCPs must assess what level of medically necessary services the member requires, determine what level of service (if any) is being provided by other entities, and then coordinate the provision of services with the other entities to ensure that MCPs and the other entities are not providing duplicative services.

MCPs have the primary responsibility to provide all medically necessary services, including services which exceed the amount provided by LEAs, RCs, or local governmental health programs. However, these other entities must continue to meet their own requirements regarding provision of services. MCPs should not rely on a LEA program, RC, CCS, Child Health and Disability Prevention Program, local governmental health program, or other entities as the primary provider of medically necessary services. The MCP is the primary provider of such medical services except for those services that have been expressly carved out. MCPs are required to provide case management and coordination of care to ensure that members can access medically necessary medical services as determined by the MCP provider. For example, when school is not in session, MCPs must cover medically necessary services that were being provided by the LEA program when school was in session.

DHCS is amending Title 22 of the CCR to eliminate references to "EPSDT Supplemental Services." There is no distinction between EPSDT services and EPSDT Supplemental Services in practice, so it is unnecessary to have two separate categories of services. MCPs must ensure that all of their own policies and procedures, as well as the policies, procedures, and practices of any subplans, contracted providers, or subcontracted Independent Physician Associations, comply with these EPSDT requirements. DHCS, in concert with the Department of Managed Health Care, will monitor plans for compliance with these requirements.

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Dual Plan Letters. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

If you have any questions regarding the requirements of this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division
Department of Health Care Services

EPSDT PROGRAM – EMERGENCY REGULATIONS AS FILED WITH THE SECRETARY OF STATE ON APRIL 27, 1995 (R-14-93)

51184. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program Definitions.

(a) EPSDT Screening Services means:
(1) An initial, periodic, or additional health assessment of a Medi-Cal eligible individual under 21 years of age provided in accordance with the requirements of the Child Health and Disability Prevention (CHDP) program as set forth in Title 17, Sections 6800 et seq.; or
(2) A health assessment, examination, or evaluation of a Medi-Cal eligible individual under 21 years of age by a licensed health care professional acting within his or her scope of practice, at intervals other than those specified in paragraph (a) (1) to determine the existence of physical or mental illnesses or conditions; or
(3) Any other encounter with a licensed health care professional that results in the determination of the existence of a suspected illness or condition or a change or complication in condition for a Medi-Cal eligible person under 21 years of age.

(b) EPSDT diagnosis and treatment services means only those services provided to persons under 21 years of age that:
(1) Are identified in section 1396d(r) of title 42 of the United States Code.
(2) Are available under this chapter without regard to the age of the recipient or that are provided to persons under 21 years of age pursuant to any provision of federal Medicaid law other than section 1396d (a) (4) (b) and section 1396a (a) (43) of title 42 of the United States Code, and
(3) Meet the standards and requirements of Sections 51003 and 51303, and any specific requirements applicable to a particular service that are based on the standards and requirements of those sections.

(c) EPSDT supplemental services means health care, diagnostic services, treatment, and other measures, that:
(1) Are identified in Section 1396d(r) of Title 42 of the United States Code.
(2) Are available only to persons under 21 years of age.
(3) Meet any one of the standards of medical necessity as set forth in paragraphs (1), (2), or (3) of Section 51340(e) and
(4) Are not EPSDT diagnosis and treatment services.

(d) EPSDT supplemental services include EPSDT case management services when provided by EPSDR case managers described in paragraph (h) (4).
(e) EPSDT diagnosis and treatment provider means any of the providers listed under Session 51051, other than EPSDT supplemental services providers.
(f) EPSDT Supplemental Services Provider means a person enrolled pursuant to Session 51242 to provide EPSDT supplemental services as defined in subsection (c).
(g) EPSDT case management services means services that will assist EPSDT eligible individuals gaining access to needed medical, social, educational, and other services.

(h) EPSDT case manager means:
(1) A targeted case management (TCM) provider under contract with a local governmental agency described in Section 14132.44 of the Welfare and Institutions Code.
(2) Entities and organizations, including Regional Centers, that provide TCM services to persons described in Section 14132.48 of the Welfare and Institutions Code.
(3) A unit within the Department designated by the Director.
(4) A child protection agency, other agency or entity serving children, or an individual provider, that the Department finds qualified by education, training, or experience, and that the Department enrolls pursuant to Section 51242 to provide EPSDT case management services.

(I) For purposes of the EPSDT program, the term "services" is deemed to include supplies, items, or equipment.

51242. EPSDT Diagnosis and Treatment Provider and EPSDT Supplemental Services Provider.

(a) An EPSDT diagnosis and treatment provider shall meet the requirements for participation in the Medi-Cal program as specified in this chapter, excepting the requirements specified in subsection (b).
(b) A provider seeking to provide EPSDT supplemental services, who is not enrolled as a provider pursuant to subsection (a), shall first submit a provider enrollment application to the Department to become an EPSDT supplemental services provider. The application shall be accompanied by a request for prior authorization, pursuant to Section 51340(c) , for the initial service the provider seeks to provide.
(c) An EPSDT case manager, defined in Section 51184 (h) (4), seeking to provide EPSDT case management services shall be considered to be an EPSDT supplemental services provider and shall comply with the requirements of this section.
(d) In order to be approved as an EPSDT supplemental services provider for the particular service sought, the provider shall supply documentation or other evidence which the Department determines establishes that all of the following conditions are met:
(1) The service to be provided meets the standard of medical necessity set forth in Section 51340 (e).
(2) The provider is licensed, certified, or otherwise recognized or authorized under state law governing the healing arts ro provide the service, and meets any applicable requirements in federal Medicaid law to provide the particular service requested.

(e) Notwithstanding the provisions of paragraph (d) (1), and entity or individual seeking to provide EPSDT case management services pursuant to Section 51340 (j) (3) shall supply documentation enacting the Department to determine that both of the following requirements are met:

(1) The criteria specified in Section 51340 (f) are met.
(2) The entity or individual is qualified by education, training, or experience to provide EPSDT case management services to the beneficiary.

(f) The Department shall not approve an application pursuant to subsection (b) or (c) of this section if the Department determines that the service to be provided is accessible and available in an appropriate and timely manner through existing Medi-Cal certified provider types or other Medi-Cal programs.
(g) Once enrolled as an EPSDT supplemental services provider, the provider shall remain enrolled only for the purpose of providing subsequent EPSDT supplemental services within his or her scope of practice, unless disenrolled.
(h) A provider who is currently enrolled as a Medi-Cal services provider shall not be required to enroll as an EPSDT supplemental services provider.

51304. Benefit Limitations

(a) Program coverage of services specified in Sections 51308, 51308.5, 51309, 51310, 51312, and 51331(a) (3) through (9), unless noted otherwise, is limited to a maximum of two services from among those services set forth in those sections in any one calendar month.
(b) For purposed of this section, "services" means al care, treatment, or procedures provided a beneficiary by an individual practitioner on one occasion.

51340. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Supplemental Services.

(a) EPSDT screening services as defined in Section 51184 (a) (1) are a program benefit when provided through the Child Health and Disability Prevention program in accordance with Title 17, California Code of Regulations, Sections 6800 et seq. EPSDT screening services as defined in Sections 51184 (a) (2) and (a) (3) are covered when provided by a certified Medi-Cal provider meeting the requirements of this chapter, if such services are otherwise reimbursable under the program.
(b) EPSDT diagnosis and treatment services as defined in Section 51184 (b) are covered subject to the provisions of this chapter.
(c) EPSDT supplemental services are covered subject to prior authorization if the requirements of subsections (e) or (f), as appropriate, are met. The Department shall review requests for services resulting form EPSDT screening services for compliance with this section whether the screen was performed by a Medi-Cal provider for a non-Medi-Cal provider.
(d) Requests for prior authorization for EPSDT supplemental services pursuant to subsection (c) shall state explicitly that the request is for EPSDT supplemental services, and shall be accompanied by the following information:
(1) The principal diagnosis and significant associated diagnosis.
(2) Prognosis.
(3) Date of onset of the illness or condition, and etiology if known
(4) Clinical significance or functional impairment caused by the illness or conditions.
(5) Specific types of services to be rendered by each discipline with physicians's prescription where applicable.

(6) The therapeutic goals to be achieved by each discipline, and anticipated time for achievement of goals.
(7) The extent to which health care services have been previously provided to address the illness or condition, and results demonstrated by prior care.
(8) Any other documentation available which may assist the Department in making the determinations required by this section.

(e) EPSDT supplemental services must meet one of the following standards, as determined by the Department:
(1) The standards and requirements set forth in Sections 51003 and 51303, and any specific requirements applicable to a specific service that based on the standards and requirements of those sections other than the services-specific requirements set forth in Sections 51340.1.
(2) The service-specific requirements applicable to EPSDT Supplemental Services set forth in Section 51340.1.
(3) When the standards set forth in paragraph (e) (1) or (e) (2) are not applicable to the services being requested, all of the following criteria, where applicable.

(A) The services are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services as defined in subsection (a) of this section.
(B) The supplies, items, or equipment to be provided are medical in nature.
(C) The services are not requested solely for the convenience of the beneficiary, family, physician or another provider of services.
(D) The services are not unsafe for the individual EPSDT eligible beneficiary, and are not experimental.
(E) The services are neither primarily cosmetic in nature nor primarily for the purpose of improving the beneficiary's appearance. The correction of severe or disabling disfigurement shall not be considered to be primarily cosmetic nor primarily for the purpose of improving the beneficiary's appearance.
(F) Where alternative medically accepted modes of treatment are available, the services are the most cost effective.
(G) The services to be provided:
(1) Are generally accepted by the professional medical and dental community as effective and proven treatments for the conditions for which they are proposed to be used. Such acceptance shall be demonstrated by scientific evidence, consisting of well designed and well conducted investigations published in peer-review journals, and, when available, opinions and evaluations published by national medical and dental organizations, consensus panels, and other technology evaluation bodies. Such evidence shall demonstrate that the services can correct or ameliorate the conditions for which they are prescribed.
(2) Are within the authorized scope of practice of the provider, and are an appropriate mode of treatment of the health condition of the beneficiary.

(H) The predicted beneficial outcome of the services outweighs potential harmful effects

(l) Available scientific evidence, as described in paragraph (e)(g)1., demonstrates that the services improve the overall health outcomes as much as. or more than. established alternatives.

(f) (1) Notwithstanding subsection (e), EPSDT case management services as specified in paragraph (j) (3) may be covered for the EPSDT-eligible beneficiary when accompanied by the information described in subsection (d) of the Department determines that both of the following criteria are met:

(A) The service to which access is to be gained through case management is medically necessary for the EPSDT-eligible beneficiary. For purposes of this subsection, medical necessity is established if the service meets the criteria set forth in subsection (e) (1), (e) (2), or (e) (3).

(B) The EPSDT-eligible beneficiary has a medical or mental health condition or diagnosis.

(2) Requests for EPSDT case management services shall not be approved if the Department determines that EPSDT case management services appropriate to the EPSDT-eligible beneficiary's needs can reasonable be obtained through the use of family, agency, or institutional assistance that is typically used by the general public in assuring that children obtain necessary medical, social, education, or other services. In making the determination described in this paragraph, the Department may take into account the following factors:

(A) Whether or not the beneficiary has a complicated medical condition, including a history of multiple or complex medical or mental health diagnosis, frequent recent hospitalization, use of emergency rooms, or other indicators of medical or mental health conditions resulting in significant impairment.

(B) Whether or not the beneficiary has a history of one or more environmental risk factors, including:

(1) parent, guardian, or primary care giver mental retardation or mental illness, physical or sensory disability, substance abuse under age 18 years, prolonged absence, or

(2) other environmental stressors, which may result in neglect, abuse, lack of stable housing, or otherwise compromise the parent's guardian's, or primary caregiver's ability to assist the beneficiary in gaining access to the necessary medical, social educational, and other services.

(g) If reimbursement is being sought on a "by report" basis, a description of the services, the proposed unit of service, and the request dollar amount shall be included with the request for authorization, A "by report" service or item is any service for which a maximum allowance has not been established because the item is rarely billed to Med-Cal program or because the service is unusual variable or new.

(h) EPSDT supplemental services requested as a result of EPSDT screening services are exempt form the benefit limitations in Section 51304, and may be covered subject to prior authorization as defined in Section 51003 if the requirements of subsection (e) of this section are met.

(i) Regardless of the source of the referral for the service, requests for EPSDT diagnostic and treatment services and EPSDT supplemental services pursuant to the requirements of this chapter shall be reviewed pursuant to this section.

(j) (1) Requests for EPSDT case management services shall not be authorized where the Department has determined that appropriate case management services may be obtained through a targeted case management (TCM) provider under contract with a participating local governmental agency that has elected to provide case management services pursuant to Section 14132.44 of the Welfare and Institutions Code, or where TCM services are available pursuant to Section 14132.48 of the Welfare and Institutions Code.

(2) Where the Department determines that EPSDT case management services are not provided or available pursuant to paragraph (j) (1), requests for EPSDT case management services may be referred to the unit within the Department designated by the Director.

(3) Where the Department determines that EPSDT case management services are not provided or available pursuant to paragraph (j) (1) or (j) (2), the Department may authorize EPSDT case management services through an EPSDT case manager described in Section 51184-(h) (4).

(k) For members of Medi-Cal managed care plans, the Medi-Cal managed care plan shall determine whether EPSDT case management services are medically necessary based on subsection (f). If the plan determines EPSDT case management services are medically necessary, the plan shall refer the members to an appropriate EPSDT case manager described in paragraph (h) (1) or (h) (2) of Section 51184. Services shall first be sought pursuant to paragraph (j) (1). If services are not available pursuant to paragraph (j) (1), the plan shall provide, or arrange and pay for, the EPSDT case management services. For purposes of this subsection, Medi-Cal managed care plan means any entity that has entered into a contract with the Department to provide, or arrange for, comprehensive health care to enrolled Medi-Cal beneficiaries pursuant to Chapter 8 or Articles 2.7, 2.8, 2.9, and 2.91 of Chapter 7 of Part 3, Division 9, of the Welfare and Institutions Code.

(l) The Department shall not approve an EPSDT supplemental service pursuant to this section if the Department determines that the service to be provided is accessible and available in an appropriate and timely manner as an EPSDT diagnostic and treatment service.

(m) The Department shall not approve a request for EPSDT diagnostic and treatment services or EPSDT supplemental services in home and community-based settings if the Department determines that the total cost incurred by the Medi-Cal program for providing such services to the beneficiary is greater that the total cost incurred by the Medi-Cal program for providing such services to the beneficiary is greater than the total costs incurred by 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.

51340.1 Requirements Applicable to EPSDT Supplemental Services

When service-specific criteria and other requirements set forth in this section are applicable to a particular EPSDT Supplemental Service, the request for service shall be approved only when such criteria and requirements are met. Requests for all other EPSDT Supplemental Services shall be approved only when the requirements set forth in Section 51340 (e) (1) or (e) (3) are met.

(a) Dental Services

(1) Dental services, other than orthodontic services

Requests for dental services, as EPSDT Supplemental Services, including but not limited to services necessary for the relief of pain and infections, restoration of teeth or maintenance of dental health, shall be evaluated under Section 51340 (e)(1) or (e)(3) as applicable.

(2) Orthodontic services

Orthodontic services are covered only:

(A) When medically necessary pursuant to the criteria set forth in the Medi-Cal "Manual of Criteria for Medi-Cal Authorization, " Chapter 8.1, as incorporated by reference in Section 51003(e), or
(B) When medically necessary for the relief of pain and infections, restoration of teeth maintenance of dental health, or the treatment of other conditions of defects, pursuant to the criteria set forth in Section 51340 (e) (1) or (e) (3), as applicable.

(b) Hearing Service

(1) Requests for hearing services, as EPSDT Supplemental Services, including but not limited to services necessary for the diagnosis and treatment for defects in hearing, including hearing aids, shall be evaluated under Section 51340 (e)(1) or (e) (3), as possible
(2) When a hearing aid is approved under the standards of Section 51340 (e) (3), one package of six hearing aid batteries, size 675, 13, 312 or 10A, may be furnished on a quarterly basis without prior authorization. Batteries in sizes other than those listed, and hearing aid batteries provided at more frequent intervals, shall be subject to prior authorization.

51532. Early and Periodic Screening. Diagnosis, and Treatment (EPSDT) Services.

(a) Reimbursement for early and periodic screening services under the Child Health and Disability Prevention program shall be make in accordance with the provisions of the Title 17, California Code of Regulations, Sections 6800 et seq.
(b) EPSDT screening services not provided through CHDP providers shall be reimbursed up to the maximum allowance for services set forth in this article.
(c) EPSDT diagnosis and treatment services, and services authorized as EPSDT Supplemental Services in excess of the maximum number of services specified in Section 51304, shall be reimbursed up to the maximum allowance for services set forth in this article. Reimbursement for EPSDT supplemental services not set forth in this article shall be based upon a review of such services to determine their relationship to other services for which maximum allowances are set forth.
(d) Reimbursement for EPSDT case management services provided by entities or individuals serving EPSDT-eligible beneficiaries pursuant to Section 51340 (j)(3) shall not duplicate reimbursement provided under other publicly funded programs.
(e) Reimbursement for EPSDT case management services provided pursuant to Section 51340 (k) shall be in accordance with the provisions of the contracts between the Department and the Medi-Cal managed care plan.

CHAPTER
8

Consumer Notices/ Grievances and Appeals

Introduction

All beneficiaries/consumers of RCDMH services shall have the right to file a grievance. A beneficiary/consumer grievance process and a Medi-Cal or RCHC beneficiary appeal process provide mental health beneficiaries or their representatives and other consumers of mental health services, with a method for resolving their concerns. Throughout the grievance and appeal processes, beneficiaries/consumers will be informed of their rights and of the steps available to them to exercise those rights.

Beneficiary Informing Materials

The RCDMH contract providers will provide beneficiaries with a copy of the informing materials upon request, when the beneficiary initially accesses services, and annually thereafter as long as they remain in treatment. The informing materials contain a description of services available, the process for obtaining the services, beneficiary rights, the right to request a change of providers, confidentiality rights, advance directive information, a list of network providers and a description of the beneficiary problem resolution process. The information provided will include both the grievance and appeals processes and will state that a Medi-Cal or RCHC beneficiary may request a State Fair Hearing after they have completed the problem resolution process. A complete list of the forms/posters is included on the Informing Materials Reorder Form (Attachment 29).

The Grievance Procedure and Appeal Procedure pamphlets and forms will be readily accessible and visibly posted in prominent locations in beneficiary and staff areas, including beneficiary waiting areas. Self addressed envelopes for mailing grievances and/or appeals to Outpatient QI will be located next to the descriptions of the Grievance Procedure and the Appeal Procedure. The grievance, appeals, and self-addressed envelopes must be available to the beneficiary and/or beneficiary representative without the beneficiary and/or beneficiary representative having to make a verbal or written request to anyone.

A notice will be conspicuously displayed in all mental health facilities advising beneficiaries to contact the contract provider, contract provider management, clinician, clinic supervisor, program manager, Patient Rights Advocate, CARES Unit, or Outpatient QI if they wish to register a grievance and/or appeal. Grievance and/or appeal information will be available through the CARES Unit's 24-hour statewide toll free number, (800) 706-7500, as well as through the Outpatient QI Grievance Line, (800) 660-3570.

The beneficiary may authorize another person to act on his/her behalf. For example, the beneficiary may ask the service provider, a friend, a family member, legal representative, or Patients' Rights staff. At the beneficiary's request, that person may act on the beneficiary's behalf in the use of the complaint grievance/appeal process.

Beneficiaries will not be subject to discrimination or any other penalty for a filing a grievance, appeal, or State Fair Hearing. The procedure for the process shall insure the confidentiality of a beneficiary's

record. Informed consent shall be obtained from beneficiaries when any information or records are released to anyone not specifically authorized by law to have access.

Grievance Process

A beneficiary or beneficiary's representative or consumer may file a grievance, orally or in writing with his/her provider, the CARES Unit, or Outpatient QI. An example of a grievance might be as follows: the quality of care of services provided, aspects of interpersonal relationships such as rudeness of an employee, etc.

When a beneficiary/consumer submits a grievance to a contract provider, the contract provider will register the receipt of the grievance in their grievance log within one (1) working day and immediately fax a copy of the grievance to Outpatient QI at (951) 955-7203. Although a beneficiary is not required to complete a grievance form, it will be necessary for the provider to write pertinent information on the form to fax to Outpatient QI. Outpatient QI will also register the grievance in their grievance log within one (1) working day.

When the beneficiary/consumer mails a grievance form directly to Outpatient QI, the program will register the receipt of the grievance in the grievance log within one (1) working day.

The grievance log will indicate: (a) the name of the beneficiary/consumer, (b) the date of the receipt of the grievance, (c) the nature of the problem and (d) final disposition of the grievance, including the date the decision is sent to the beneficiary, or documentation of the reason(s) that there has not been final disposition of the grievance.

A letter acknowledging the receipt of the grievance will be sent by Outpatient QI to the beneficiary/consumer within ten (10) working days. Beneficiaries/beneficiary representatives can request assistance with the grievance process, or obtain information on the status of a pending grievance by calling Outpatient QI's Grievance Line at the statewide toll-free number (800) 660-3570.

Every effort to provide for resolution of the beneficiary's/consumer's grievance as quickly and simply as possible will be made by the recipient of the grievance. Resolution may be reached through discussions between the beneficiary/consumer, or the beneficiary's representative and the therapist, case manager, program supervisor, or other persons involved in the matter at hand. If the contract provider reaches resolution of the beneficiary's grievance, the contract provider will notify Outpatient QI of the resolution. Outpatient QI will review and approve the resolution.

The contract provider and/or Outpatient QI will insure that the person reviewing a grievance, also known as the decision-maker; will not have been involved in any previous level of review or decision making with a grievance.

The beneficiary/representative/consumer will be sent a written decision on the grievance within sixty (60) calendar days of receipt of the grievance by Outpatient QI. Outpatient QI will also send a written notification to those contract providers cited by the beneficiary/consumer or otherwise involved in the grievance regarding the final disposition of the beneficiary's grievance.

The timeframe may be extended by up to fourteen (14) calendar days if the beneficiary/ representative/consumer requests an extension, or if Outpatient QI on behalf of the MHP determines that there is a need for additional information and that the delay is in the beneficiary's/consumer's interest. Outpatient QI will send a written notification to the beneficiary/representative/consumer and the contract provider when an extension has occurred. The written notification will explain the reason for the extension.

Outpatient QI and the contract provider will record the final disposition of the grievance in their grievance log. The record will include the date the decision was sent to the beneficiary or document the reason(s) that there has not been a final disposition of the grievance.

If a beneficiary/beneficiary representative or consumer is dissatisfied with the grievance decision, the beneficiary/beneficiary representative or consumer may be referred to Outpatient QI for further review.

Notice of Denial, Termination, or Reduction of Services

The provider shall fully inform beneficiaries orally and in language accessible to them of any proposed denial, termination, or reduction in their mental health treatment or service. Any written communication with a beneficiary regarding a denial, termination, or reduction of services will be written in clear, concise language, in a format understandable to the beneficiary/consumer.

Written notice shall be provided at the time of the change of service when a change in the level of mental health services is prescribed by the beneficiary's/consumers' treating professional (See Definitions Section for "denial," "termination," "reduction in services," and "notice of action").

The provider shall specify the service(s) to be denied, terminated, or reduced, the reasons therefore and the date of action. Reasons given may include:

> The beneficiary/consumer no longer meets the medical necessity requirements for eligibility for a specific mental health service.
>
> The beneficiary/consumer has obtained maximum therapeutic benefit and mental health services are no longer indicated.
>
> The beneficiary/consumer has willfully and persistently failed to comply with the agreed-upon and prescribed treatment plan.
>
> The program does not provide the services the patient requests.

The provider shall make all appropriate efforts to assist beneficiaries in preparing for the action, including, but not limited to, pointing out alternative resources and/or support such as self-help groups and free community services.

If the beneficiary/consumer disagrees with the action of the service provider they have a right to an Appeal.

Appeal Procedures

Non-expedited Appeal – Medi-Cal or RCHC Beneficiaries

An appeal may be filed, orally or in writing, with the contract provider, contract management, the CARES Unit or Outpatient QI. An appeal is a request for a review of an action by the authorization unit (CARES) or county clinic. An action is defined as the modification or denial of a requested service from a beneficiary and/or a reduction, suspension, or termination of a previously authorized service. An oral appeal must be followed up with a written, signed appeal. Medi-Cal or RCHC beneficiaries may file for a State Fair Hearing after they have completed the problem resolution process. Forms and self-addressed envelopes will be available at all county-operated or contracted mental health facilities. Beneficiaries/beneficiary representatives can request assistance with the appeal process or obtain information on the status of a pending appeal by calling Outpatient QI's Grievance Line at the statewide toll-free number (800) 660-3570.

The beneficiary/beneficiary's representative may begin the appeal process, orally or by completing an appeal request form and a release of information form, when applicable. Oral appeals must be followed up with written, signed appeal and a release of information form, when applicable. Self-addressed envelopes addressed to Outpatient QI will be available for beneficiary/beneficiary's representative to use to submit their appeal request.

The appeal form should indicate if the beneficiary is in any Medi-Cal or RCHC funded residential treatment program.

The beneficiary/beneficiary's representative will be given a reasonable opportunity to present evidence and allegations of fact or law in regard to the appeal requested in person or in writing to Outpatient QI.

The beneficiary/beneficiary's representative will also be given a reasonable opportunity, when requested, to examine the beneficiary's case file, including medical records and any other documents or records considered applicable to the appeal process.

Outpatient QI will receive and process all appeal requests. Contract providers will fax the appeal to Outpatient QI upon receipt of the appeal. The appeal will be processed as follows:

- Outpatient QI will enter the appeal into the Appeal Log within one (1) working day of receipt. The Appeal Log will indicate: (a) the name of the beneficiary, (b) the date of the receipt of the appeal, (c) the nature of the problem, and (d) final disposition of the appeal, including the date the written decision is sent to the beneficiary/beneficiary's representative, or documentation of the reason(s) that there has not been a final disposition of the appeal, including the date the written decision is sent to the beneficiary, or documentation of the reason(s) that there has not been a final disposition of the grievance.

- A letter acknowledging the receipt of the appeal will be sent to the beneficiary within ten (10) working days. The letter will also inform a Medi-Cal or RCHC beneficiary of his/her right to request a State Fair Hearing after they have completed the problem resolution process. Outpatient QI will be responsible for monitoring the appeal process to ensure that resolution of the appeal is within the appropriate timelines.

Outpatient QI will notify the involved inpatient facility or contract provider of the pending appeal. A decision about the appeal may be reached through discussions between the beneficiary, or the beneficiary's representative and the RCDMH program, contract providers, or other persons involved in the matter at hand.

Outpatient QI will insure that the person reviewing an appeal, also known as the decision-maker; will not have been involved in any previous level of review or decision making with the appeal.

Outpatient QI will be responsible for notifying the beneficiary/beneficiary's representative of the decision in writing within forty-five (45) calendar days of the receipt of the appeal. The notice will contain the following:

- The results of the appeal resolution process.
- The date that the appeal decision was made.
- If the appeal is not resolved wholly in favor of the Medi-Cal or RCHC beneficiary, the notice will also contain information regarding the beneficiary's right to a State Fair Hearing and the procedure for filing for a State Fair Hearing. The notice will also inform the Medi-Cal or RCHC beneficiary of their right to request and receive benefits while the State Fair Hearing is pending and the procedure for making the request.

The timeframe may be extended by up to fourteen (14) calendar days if the beneficiary request an extension and Outpatient QI determines that there is a need for additional information and that the delay is in the beneficiary's interest. Outpatient QI will also send a written notification to the beneficiary and/or the beneficiary's representative and all other affected parties when an extension has occurred. The written notification will explain the reason for the extension.

If the Medi-Cal or RCHC beneficiary/beneficiary's representative and/or provider are not notified of the appeal within the forty-five (45) calendar days of receipt of the appeal or have not requested an extension form the Medi-Cal or RCHC beneficiary, a Notice of Action form will be sent to the Medi-Cal or RCHC beneficiary/beneficiary's representative advising them of their right to request a Sate Fair Hearing. The Notice of Action letter will be sent on the date that the 45-calendar day period expires.

Outpatient QI will record the final disposition of the appeal, including the date the decision was sent to the beneficiary/beneficiary's representative, or document the reason(s) that there has not been a final disposition of the appeal in the Appeal Log. Notification efforts will be documented in the log if the beneficiary/beneficiary's representative cannot be contacted orally or in writing.

Outpatient QI will notify those providers cited by the beneficiary/beneficiary's representative or otherwise involved in the appeal of the final disposition of the beneficiary's appeal.

Expedited Appeal: Medi-Cal or RCHC Beneficiary

An appeal will be handled in an expedited manner when Outpatient QI determines, or the beneficiary or the provider request that taking the time for a standard resolution of an appeal could seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function. The Expedited Appeals block should be checked on the appeal form. When this block is checked the appeal will be processed within the Expedited Appeal guidelines.

The beneficiary's mental health specialty services will continue until there is a response to the expedited appeal from Outpatient QI, unless the beneficiary poses a threat to the safety of other beneficiaries receiving services in a residential or outpatient facility. Expedited appeals received by RCDMH program or contract provider will be faxed to Outpatient QI.

A beneficiary/beneficiary's representative will be allowed to file the request for an expedited appeal orally, without a written follow-up, or by using the Appeal form and checking the "expedited appeal" box on the form.

Outpatient QI will register the receipt of the expedited appeal in the Appeal Log within one (1) working day of receipt and indicate that the appeal is an expedited appeal request.

When Outpatient QI receives the expedited appeal from the beneficiary/beneficiary's representative, Outpatient QI will have three (3) working days from receipt to review the expedited appeal and to seek resolution with the beneficiary/beneficiary's representative either in person or by telephone. Outpatient QI will insure that the person reviewing the expedited appeal, also known as the decision-maker, will not have been involved in any previous level of review or decision making with the expedited appeal.

By the end of the third (3rd) working day, a written notification summarizing the discussion and the proposed resolution of the expedited appeal shall be given to the beneficiary/beneficiary's representative. The letter will contain the following:

- The results of the expedited appeal resolution process.
- The date that the expedited appeal decision was made.
- If the expedited appeal is not resolved wholly in favor of the Medi-Cal or RCHC beneficiary, the notice will contain information regarding the beneficiary's right to a State Fair Hearing and the procedure for filing a State Fair Hearing.
- The availability of assistance to complete the form for a State Fair Hearing will be given to any Medi-Cal or RCHC beneficiary/beneficiary's representative who wishes to appeal the expedited appeal decisions.

Timeframes may be extended up to fourteen (14) calendar days if the beneficiary request an extension or Outpatient QI determines that there is a need for additional information and that the delay is in the beneficiary's interest. Outpatient QI will send written notification to the beneficiary/beneficiary's representative and all other affected parties when either party has requested an extension. The written notification will explain the reason for the extension.

If Outpatient QI denies a request for an expedited resolution of an appeal, Outpatient QI will: (a) transfer the appeal to the timeframe for a standard appeal resolution and (b) make a reasonable effort to give the beneficiary and his/her representative prompt oral notice of the denial of the expedited appeal process and follow up within two (2) calendar days with a written notice.

Grievances Regarding CARES or ACT

When a complaint is received from the Department of Social Services (DPSS) against a contract provider of the MHP and/or an employee of the Department of Mental Health (DMH), the complaint will be logged by the recipient of the complaint and processed in accordance with the grievance procedure.

When a complaint is received from a beneficiary/beneficiary's representative about an employee of the CARES Unit and/or the ACT the beneficiary/beneficiary's representative will be encouraged to call the supervisor of that employee. The beneficiary/beneficiary's representative will be asked if they would like to file a grievance. All complaints/grievances will be processed in accordance with the grievance procedure.

If a beneficiary/beneficiary's representative is dissatisfied with the grievance decision the beneficiary/ beneficiary's representative may be referred to QI for further review.

Outpatient Quality Improvement (Outpt QI) – Grievance Process and Appeal Process Review

QI will have a process in place to monitor the grievance process and appeal process to identify and address systemic problems or weaknesses. QI will forward a summary of the issues identified in the grievance or appeal processes to RCDMH management for review and, if applicable, implementation of needed system changes.

State Fair Hearing

State and Federal law guarantees Medi-Cal or RCHC beneficiaries a right to a State Fair Hearing after they have completed the problem resolution process. Beneficiaries are to be notified, orally if possible, and in writing when services are being denied, terminated, or reduced. The Notice of Action (NOA) will inform Medi-Cal or RCHC beneficiaries of their right to request State a Fair Hearing within ninety (90) calendar days of the date of the notice. In addition, if the beneficiary requests a State Fair Hearing within ten (10) days of the date of the notice, the beneficiary is entitled to continue to receive services until the Fair Hearing decision is made under the Aid Paid Pending clause when:

The CARES Unit reduces or terminates services, and
The beneficiary is currently receiving services.

The request for a State Fair Hearing is completed by the Medi-Cal or RCHC beneficiary and mailed directly to the Administrative Adjudications Division in Sacramento. Hearings are held

within thirty (30) days of the request, and involved parties are notified ten (10) days prior to the hearing. The Department will prepare a position paper concerning the issues, which must be given to the beneficiary/beneficiary's representative at least two (2) days prior to the hearing.

Enforcement

Mental health providers must abide by the decisions of the State Fair Hearing regarding treatment services provided to beneficiaries.

The Mental Health Director is responsible for assuring that the State Fair Hearing decision is followed. Failure to implement the recommendation or decision could result in disciplinary action, fines or revocation of contract as imposed by the Mental Health Director.

Confidentiality

Grievance and Appeal procedures shall ensure the confidentiality of beneficiary/consumer records. Informed consent shall be obtained from beneficiaries/consumers when any information or records are released to anyone not specifically authorized by law to have access.

Consumer Problem Resolution

RCDMH is committed to maintaining quality services for Riverside County consumers, and is mindful that there may be many factors contributing to a consumer's dissatisfaction. Complaints/Grievances about providers will be investigated by RCDMH Outpatient Quality Improvement.

Most complaints are minor and can be easily resolved on an informal level, while other situations may be more complex and may involve a written follow-up. In less frequent situations providers may be placed on a "QI Hold" while a situation is being investigated. Being placed on "hold" is dependent on the severity of the concern, pattern of past complaints, and the impact on the consumer(s). Providers will be notified in writing of the hold.

Providers will be notified via certified mail of contract termination.

Definitions

Reduction in Service: Any reduction in the mode or method of services, including but not limited to a reduction in the frequency or duration or in accessibility of location of provider.

Beneficiary/Consumer Assistant: A person appointed by each provider of mental health services located at the provider site whose function it is to assist beneficiaries with the grievance procedure. The beneficiary/consumer assistant may be an employee of the provider and may have other responsibilities in addition to assisting beneficiaries.

Denial of Service: A refusal on the part of the provider, provider staff, or managed care system to deliver the type, mode or method of mental health treatment or services requested by the applicant of a requested service, beneficiary/consumer, or of a person lawfully entitled to consent for treatment on the beneficiary's/consumers' or consumer representative's behalf.

State Fair Hearing (Medi-Cal or RCHC): The formal hearing described in "Beneficiary/Consumer Notices," Section 431.200 et seq. of the federal Regulations and Section 10950 et seq. of the Welfare and Institutions Code.

Mental Health Director: The County-designated Mental Health Director or the County-designated Regional Program Manager providing the managed care service for a county.

Notice of Action: Formal written and whenever possible oral notification to the beneficiary/consumer of any denial, change or termination of treatment or services. The notice should specify the proposed action and reasons therefore, effective dates of the action and grievance procedures available.

Patients' Rights: The persons designated in the Welfare and Institutions Code Section 5500 et seq. to protect the rights of all recipients of mental health services.

Termination of Service: The cessation or suspension of any mode or method of treatment of services the beneficiary/consumer has been receiving due to a decision made by the mental health care provider and/or managed care system.

GRIEVANCE LOG

Date Received	Beneficiary Name	Complainant Name	Description of Complaint	Agreed Resolution Deadline	Resolution Date	How Resolved

DHCS

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: October 27, 2017

ALL PLAN LETTER 17-018
SUPERSEDES ALL PLAN LETTER 13-021

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: MEDI-CAL MANAGED CARE HEALTH PLAN RESPONSIBILITIES FOR OUTPATIENT MENTAL HEALTH SERVICES

PURPOSE:

The purpose of this All Plan Letter (APL) is to explain the contractual responsibilities of Medi-Cal managed care health plans (MCPs) for the provision of medically necessary outpatient mental health services and the regulatory requirements for the Medicaid Mental Health Parity Final Rule (CMS-2333-F). MCPs must provide specified services to adults diagnosed with a mental health disorder, as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM),that results in mild to moderate distress or impairment[1] of mental, emotional, or behavioral functioning. MCPs must also provide medically necessary non-specialty mental health services[2] to children under the age of 21. This APL also delineates MCP responsibilities for referring to, and coordinating with, county Mental Health Plans (MHPs) for the delivery of specialty mental health services (SMHS).

This letter supersedes APL 13-021 and provides updates to the responsibilities of the MCPs for providing mental health services. Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice 16-061[3] describes existing requirements regarding the provision of SMHS by MHPs, which have not changed as a result of coverage of non-specialty, outpatient mental health services by MCPs and the fee-for-service (FFS) Medi-Cal program. The requirements outlined in Information Notice 16-061 remain in effect.

[1] DHCS recognizes that the medical necessity criteria for impairment and intervention for Medi-Cal SMHS differ between children and adults. For children and youth, under EPSDT, the "impairment" criteria component of SMHS, medical necessity is less stringent than it is for adults; therefore, children with low levels of impairment may meet medical necessity criteria SMHS (CCR, Title 9 Sections § 1830.205 and §1830.210).
[2] The term "non-specialty" in this context is used to differentiate the mental health services covered and provided by MCPs and the FFS Medi-Cal program from the SMHS covered and provided by MHPs. It is not intended to describe the providers of these services as non-specialist providers.
[3] MHSUDS Information Notices are available at: http://www.dhcs.ca.gov/formsandpubs/Pages/MHSUDS-Information-Notices.aspx

BACKGROUND:

The federal Section 1915(b) Medi-Cal SMHS Waiver[4] requires Medi-Cal beneficiaries needing SMHS to access these services through MHPs. To qualify for these services, beneficiaries must meet SMHS medical necessity criteria regarding diagnosis, impairment, and expectations for intervention, as specified below. Medical necessity criteria differ depending on whether the determination is for:

1. Inpatient services;
2. Outpatient services; or
3. Outpatient services (Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)).

The medical necessity criteria for SMHS can be found in Title 9, California Code of Regulations (CCR), Sections (§) 1820.205 (inpatient)[5]; 1830.205 (outpatient)[6]; and 1830.210 (outpatient EPSDT)[7].

DHCS recognizes that the medical necessity criteria for impairment and intervention for Medi-Cal SMHS differs between children and adults. For children and youth, under EPSDT, the "impairment" criteria component of SMHS medical necessity is less stringent than it is for adults, therefore children with low levels of impairment may meet medical necessity criteria for SMHS (Title 9, CCR, §1830.205 and §1830.210), whereas adults must have a significant level of impairment. To receive SMHS, Medi-Cal children and youth must have a covered diagnosis and meet the following criteria:

1. Have a condition that would not be responsive to physical health care based treatment; and
2. The services are necessary to correct or ameliorate a mental illness and condition discovered by a screening conducted by the MCP, the Child Health and Disability Prevention Program, or any qualified provider operating within the scope of his or her practice, as defined by state law regardless of whether or not that provider is a Medi-Cal provider.

Consistent with Title 9, CCR, §1830.205, an adult beneficiary must meet all of the following criteria to receive outpatient SMHS:

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[4] SHMS Waiver Information can be found at:
http://www.dhcs.ca.gov/services/MH/Pages/1915(b)_Medi-cal_Specialty_Mental_Health_Waiver.aspx
[5] Medical necessity criteria for inpatient specialty mental health services (Title 9, CCR, §1820.205) are not described in detail in this APL, as this APL is primarily focused on outpatient mental health services.
[6] Title 9, CCR, §1830.205
[7] Title 9, CCR, §1830.210

1. The beneficiary has one or more diagnoses covered by Title 9, CCR, §1830.205(b)(1), whether or not additional diagnoses, not included in Title 9, CCR, §1830.205(b)(1) are also present.
2. The beneficiary must have at least one of the following impairments as a result of the covered mental health diagnosis:
   a. A significant impairment in an important area of life functioning; or
   b. A reasonable probability of significant deterioration in an important area of life functioning.
3. The proposed intervention is to address the impairment resulting from the covered diagnosis, with the expectation that the proposed intervention will significantly diminish the impairment, prevent significant deterioration in an important area of life functioning, In addition, the beneficiary's condition would not be responsive to physical health care based treatment.

Prior to January 1, 2014, adult MCP beneficiaries who had mental health conditions but did not meet the medical necessity criteria for SMHS had only limited access to outpatient mental health services, which were delivered by primary care providers (PCPs) or by referral to Medi-Cal FFS mental health providers. DHCS paid MCPs a capitated rate to provide those outpatient mental health services that were within the PCP's scope of practice (unless otherwise excluded by contract). Since January 1, 2014, DHCS adjusted MCP capitation payments to account for expanded outpatient mental health services.

DHCS requires MCPs to cover and pay for mental health services conducted by licensed mental health professionals (as specified in the Psychological Services Medi-Cal Provider Manual[8]) for MCP beneficiaries with potential mental health disorders, in accordance with Sections 29 and 30 of Senate Bill X1 1 of the First Extraordinary Session (Hernandez & Steinberg, Chapter 4, Statutes of 2013), which added §14132.03 and §14189 to the Welfare and Institutions Code. This requirement, which was in addition to the previously-existing requirement that PCPs offer mental health services within their scope of practice, remains in effect, along with the requirement to cover outpatient mental health services to adult beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning (as assessed by a licensed mental health professional through the use of a Medi-Cal-approved clinical tool or set of tools agreed upon by both the MCP and MHP) resulting from a mental health disorder (as defined in the current DSM).

[8] The Psychological Services Provider Manual can be found at:
http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/psychol_a07.doc

On March 30, 2016, the Centers for Medicare and Medicaid Services (CMS) issued a final rule (CMS-2333-F) that applied certain requirements from the Mental Health Parity and Addiction Equity Act of 2008 (Pub. L. 110-343, enacted on October 3, 2008) to coverage offered by Medicaid Managed Care Organizations. This included the addition of Subpart K – Parity in Mental Health and Substance Use Disorder Benefits to the Code of Federal Regulations (CFR). The general parity requirement (Title 42, CFR, §438.910(b)) stipulates that treatment limitations for mental health benefits may not be more restrictive than the predominant treatment limitations applied to medical or surgical benefits. This precludes any restrictions to a beneficiary's access to an initial mental health assessment. Therefore, MCPs shall not require prior authorization for an initial mental health assessment. DHCS recognizes that while many PCPs provide initial mental health assessments within their scope of practice, not all do. If a beneficiary's PCP cannot perform the mental health assessment because it is outside of their scope of practice, they may refer the beneficiary to the appropriate provider.

POLICY:

MCPs continue to be responsible for the delivery of non-SMHS for children under age 21 and outpatient mental health services for adult beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health disorder, as defined by the current DSM. MCPs shall continue to deliver the outpatient mental health services specified in their Medi-Cal Managed Care contract and listed in Attachment 1 whether they are provided by PCPs within their scope of practice or through the MCP's provider network.

MCPs also continue to be responsible for the arrangement and payment of all medically necessary, Medi-Cal-covered physical health care services, not otherwise excluded by contract, for MCP beneficiaries who require SMHS. The eligibility and medical necessity criteria for SMHS provided by MHPs have not changed pursuant to this policy; SMHS continue to be available through MHPs.

MCPs must be in compliance with Mental Health Parity requirements on October 1, 2017, as required by Title 42, CFR, §438.930. MCPs shall also ensure direct access to an initial mental health assessment by a licensed mental health provider within the MCP's provider network. MCPs shall not require a referral from a PCP or prior authorization for an initial mental health assessment performed by a network mental health provider. MCPs shall notify beneficiaries of this policy, and MCPs informing materials must clearly state that referral and prior authorization are not required for a beneficiary to seek an initial mental health assessment from a network mental health provider. An MCP is required to cover the cost of an initial mental health assessment

completed by an out-of-network provider only if there are no in-network providers that can complete the necessary service.

If further services are needed that require authorization, MCPs are required to follow guidance developed for mental health parity, as follows:

MCPs must disclose the utilization management or utilization review policies and procedures that the MCP utilizes to DHCS, its contracting provider groups, or any delegated entity, uses to authorize, modify, or deny health care services via prior authorization, concurrent authorization or retrospective authorizations, under the benefits included in the MCP contract.

MCP policies and procedures must ensure that authorization determinations are based on the medical necessity of the requested health care service in a manner that is consistent with current evidence-based clinical practice guidelines. Such utilization management policies and procedures may also take into consideration the following:

- Service type
- Appropriate service usage
- Cost and effectiveness of service and service alternatives
- Contraindications to service and service alternatives
- Potential fraud, waste and abuse
- Patient and medical safety
- Other clinically relevant factors

The policies and procedures must be consistently applied to medical/surgical, mental health and substance use disorder benefits. The plan shall notify contracting health care providers of all services that require prior authorization, concurrent authorization or retrospective authorization and ensure that all contracting health care providers are aware of the procedures and timeframes necessary to obtain authorization for these services.

The disclosure requirements for MCPs include making utilization management criteria for medical necessity determinations for mental health and substance use disorder benefits available to beneficiaries, potential beneficiaries and providers upon request in accordance with Title 42, CFR §438.915(a). MCPs must also provide to beneficiaries, the reason for any denial for reimbursement or payment of services for mental health or substance use disorder benefits in accordance with Title 42, CFR, §438.915(b). In addition, all services must be provided in a culturally and linguistically appropriate manner.

MCP Responsibility for Outpatient Mental Health Services
Attachment 1 summarizes mental health services provided by MCPs and MHPs. MCPs must provide the services listed below when medically necessary and provided by PCPs or by licensed mental health professionals in the MCP provider network within their scope of practice:

1. Individual and group mental health evaluation and treatment (psychotherapy);
2. Psychological testing, when clinically indicated to evaluate a mental health condition;
3. Outpatient services for the purposes of monitoring drug therapy;
4. Outpatient laboratory, drugs, supplies, and supplements (excluding medications listed in Attachment 2); and,
5. Psychiatric consultation.

Current Procedural Terminology (CPT) codes that are covered can be found in the Psychological Services Medi-Cal Provider Manual (linked in footnote 8 above).

Laboratory testing may include tests to determine a baseline assessment before prescribing psychiatric medications or to monitor side effects from psychiatric medications. Supplies may include laboratory supplies. Supplements may include vitamins that are not specifically excluded in the Medi-Cal formulary and that are scientifically proven effective in the treatment of mental health disorders (although none are currently indicated for this purpose).

For mild to moderate mental health MCP covered services for adults, medically necessary services are defined as reasonable and necessary services to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis and treatment of disease, illness, or injury. These include services to:

1. Diagnose a mental health condition and determine a treatment plan;
2. Provide medically necessary treatment for mental health conditions (excluding couples and family counseling for relational problems) that result in mild or moderate impairment; and,
3. Refer adults to the county MHP for SMHS when a mental health diagnosis covered by the MHP results in significant impairment;

For beneficiaries under the age of 21, the MCP is responsible for providing medically necessary non-SMHS listed in Attachment 1 regardless of the severity of the impairment. The number of visits for mental health services is not limited as long as the MCP beneficiary meets medical necessity criteria.

At any time, beneficiaries can choose to seek and obtain a mental health assessment from a licensed mental health provider within the MCP's provider network. Each MCP is still obligated to ensure that a mental health screening of beneficiaries is conducted by network PCPs. Beneficiaries with positive screening results may be further assessed either by the PCP or by referral to a network mental health provider. The beneficiary may then be treated by the PCP within the PCP's scope of practice. When the condition is beyond the PCP's scope of practice, the PCP must refer the beneficiary to a mental health provider within the MCP network. For adults, the PCP or mental health provider must use a Medi-Cal-approved clinical tool or set of tools mutually agreed upon with the MHP to assess the beneficiary's disorder, level of impairment, and appropriate care needed. The clinical assessment tool or set of tools must be identified in the MOU between the MCP and MHP, as discussed in APL 13-018.

Pursuant to the EPSDT benefit, MCPs are required to provide and cover all medically necessary services. For adults, medically necessary services include all covered services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. For children under the age 21, MCPs must provide a broader range of medically necessary services that is expanded to include standards set forth under Title 22, CCR Sections 51340 and 51340.01 and "[s]uch other necessary health care, diagnostic services, treatment, and other measures described in [Title 42, United States Code (US Code), Section 1396d(a)] to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services or items are covered under the state plan" (Title 42, US Code, Section 1396d(r)(5)). However for children under the age 21, MCPs are required to provide and cover all medically necessary service, except for SMHS listed in CCR, Title 9, Section 1810.247 for beneficiaries that meet the medical necessity criteria for SMHS as specified in to CCR, Title 9, Sections 1820.205, 1830.205, or 1830.210 that must be provided by a MHP.

If an MCP beneficiary with a mental health diagnosis is not eligible for MHP services because they do not meet the medical necessity criteria for SMHS, then the MCP is required to ensure the provision of outpatient mental health services as listed in the contract and Attachment 1 of this APL, or other appropriate services within the scope of the MCP's covered services.

Each MCP must ensure its network providers refer adult beneficiaries with significant impairment resulting from a covered mental health diagnosis to the county MHP. Also, when the adult MCP beneficiary has a significant impairment, but the diagnosis is uncertain, the MCP must ensure that the beneficiary is referred to the MHP for further assessment.

The MCPs must also cover outpatient laboratory tests, medications (excluding carved-out medications that are listed in the MCP's relevant Medi-Cal Provider Manual[9]), supplies, and supplements prescribed by the mental health providers in the MCP network, as well as by PCPs, to assess and treat mental health conditions. The MCP may require that mild to moderate mental health services to adults are provided through the MCP's provider network, subject to a medical necessity determination.

The MCP may contract with the MHP to provide these mental health services when the MCP covers payment for these services.

MCPs continue to be required to provide medical case management and cover and pay for all medically necessary Medi-Cal-covered physical health care services for an MCP beneficiary receiving SMHS. The MCP must coordinate care with the MHP. The MCP is responsible for the appropriate management of a beneficiary's mental and physical health care, which includes, but is not limited to, the coordination of all medically necessary, contractually required Medi-Cal-covered services, including mental health services, both within and outside the MCP's provider network.

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal law and regulations, as well as other contract requirements and DHCS guidance, including applicable APLs and Duals Plan Letters. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

If you have any questions regarding this APL, please contact your Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division
Department of Health Care Services

Attachments

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[9] The provider manual for the Two Plan Model can be found at:
http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/mcptwoplan_z01.doc
The provider manual for the Geographic Managed Care Model can be found at:
http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/mcpgmc_z01.doc
The provider manual for the County Organized Health Systems can be found at:
https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/.../mcpcohs_z01.doc
The provider manual for Imperial, San Benito, and Regional Models can be found at:
http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/mcpimperial_z01.doc

Attachment 1

Mental Health Services Description Chart for Beneficiaries Enrolled in an MCP

DIMENSION	MCP	MHP[10] OUTPATIENT	MHP INPATIENT
ELIGIBILITY	**Mild to Moderate Impairment in Functioning** A beneficiary is covered by the MCP for services if he or she is diagnosed with a mental health disorder, as defined by the current DSM[11], resulting in mild to moderate distress or impairment of mental, emotional, or behavioral functioning: • At an initial health screening, a PCP may identify the need for a thorough mental health assessment and refer a beneficiary to a licensed mental health provider within the MCP's network. The mental health provider can identify the mental health disorder and determine the level of impairment. • A beneficiary may seek and obtain a mental health assessment at any time directly from a licensed mental health provider within the MCP network without a referral from a PCP or prior authorization from the MCP. • The PCP or mental health provider should refer any beneficiary who meets medical necessity criteria	**Significant Impairment in Functioning** An adult beneficiary is eligible for services if he or she meets all of the following medical necessity criteria: 1. Has an included mental health diagnosis;[12] 2. Has a significant impairment in an important area of life function, or a reasonable probability of significant deterioration in an important area of life function; 3. The focus of the proposed treatment is to address the impairment(s), prevent significant deterioration in an important area of life functioning. 4. The expectation is that the proposed treatment will significantly diminish the impairment, prevent significant deterioration in an important area of life function, and 5. The condition would not be responsive to physical health care based treatment. *Note: For beneficiaries under age 21, specialty mental health services must be provided for a range of impairment levels*	**Emergency and Inpatient** A beneficiary is eligible for services if he or she meets the following medical necessity criteria: 1. An included diagnosis; 2. Cannot be safely treated at a lower level of care; 3. Requires inpatient hospital services due to one of the following which is the result of an included mental disorder: a. Symptoms or behaviors which represent a current danger to self or others, or significant property destruction; b. Symptoms or behaviors which prevent the beneficiary from providing for, or utilizing, food, clothing, or shelter; c. Symptoms or behaviors which present a severe risk to the beneficiary's physical health; d. Symptoms or behaviors which represent a recent, significant deterioration in ability to function; e. Psychiatric evaluation or treatment which can only be performed in an acute psychiatric inpatient setting or through urgent

[10] SMHS provided by MHP
[11] Current policy is based on DSM IV and will be updated to DSM 5 in the future
[12] As specified in regulations Title 9, Section 1830.205 for adults and Section 1830.210 for those under age 21

DIMENSION	MCP	MHP[10] OUTPATIENT	MHP INPATIENT
ELIGIBILITY (continued)	for SMHS to the MHP. • When a beneficiary's condition improves under SMHS and the mental health providers in the MCP and MHP coordinate care, the beneficiary may return to the MCP's network mental health provider. *Note: Conditions that the current DSM identifies as relational problems are not covered (e.g., couples counseling or family counseling.)*	*to correct or ameliorate a mental health condition or impairment.*[13]	or emergency intervention provided in the community or clinic; and; f. Serious adverse reactions to medications, procedures or therapies requiring continued hospitalization.
SERVICES	Mental health services provided by licensed mental health care professionals (as defined in the Medi-Cal provider bulletin) acting within the scope of their license: • Individual and group mental health evaluation and treatment (psychotherapy) • Psychological testing when clinically indicated to evaluate a mental health condition • Outpatient services for the purposes of monitoring medication therapy • Outpatient laboratory, medications, supplies, and supplements • Psychiatric consultation	• Mental Health Services o Assessment o Plan development o Therapy o Rehabilitation o Collateral • Medication Support Services • Day Treatment Intensive • Day Rehabilitation • Crisis Residential Treatment • Adult Residential Treatment • Crisis Intervention • Crisis Stabilization • Targeted Case Management • Intensive Care Coordination • Intensive Home Based Services • Therapeutic Foster Care • Therapeutic Behavioral Services	• Acute psychiatric inpatient hospital services • Psychiatric Health Facility Services • Psychiatric Inpatient Hospital Professional Services if the beneficiary is in fee-for-service hospital

[13] Title 9, CCR, §1830.210

Attachment 2

Drugs Excluded from MCP Coverage

The following psychiatric drugs are noncapitated except for HCP 170 (KP Cal, LLC):

Amantadine HCl	Olanzapine Fluoxetine HCl
Aripiprazole	Olanzapine Pamoate Monohydrate (Zyprexa Relprevv)
Asenapine (Saphris)	
Benztropine Mesylate	Paliperidone **(oral and injectable)**
Brexpiprazole (Rexulti)	Perphenazine
Cariprazine	Phenelzine Sulfate
Chlorpromazine HCl	Pimavanserin
Clozapine	Pimozide
Fluphenazine Decanoate	Quetiapine
Fluphenazine HCl	Risperidone
Haloperidol	Risperidone Microspheres
Haloperidol Decanoate	Selegiline (transdermal only)
Haloperidol Lactate	Thioridazine HCl
Iloperidone (Fanapt)	Thiothixene
Isocarboxazid	Thiothixene HCl
Lithium Carbonate	Tranylcypromine Sulfate
Lithium Citrate	Trifluoperazine HCl
Loxapine Succinate	Trihexyphenidyl
Lurasidone Hydrochloride	Ziprasidone
Molindone HCl	Ziprasidone Mesylate
Olanzapine	

These drugs are listed in the Medi-Cal Provider Manual in the following link:
http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/mcpgmc_z01.doc

DHCS

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: July 17, 2017

ALL PLAN LETTER 17-010 (*REVISED*)

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: NON-EMERGENCY MEDICAL AND NON-MEDICAL TRANSPORTATION SERVICES

PURPOSE:
This All Plan Letter (APL) provides Medi-Cal managed care health plans (MCPs) with guidance regarding Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services. With the passage of Assembly Bill (AB) 2394 (Chapter 615, Statutes of 2016), which amended Section 14132 of the Welfare and Institutions Code (WIC), the Department of Health Care Services (DHCS) is clarifying MCPs' obligations to provide and coordinate NEMT and NMT services. In addition, this APL provides guidance on the application of NEMT and NMT services due to the Medicaid Mental Health Parity Final Rule (CMS-2333-F)[1]. *Revised text is found in italics.*

BACKGROUND:
DHCS administers the Medi-Cal Program, which provides comprehensive health care services to millions of low-income families and individuals through contracts with MCPs. Pursuant to Social Security Act (SSA) Section 1905(a)(29) and Title 42 of the Code of Federal Regulations (CFR) Sections 440.170, 441.62, and 431.53, MCPs are required to establish procedures for the provision of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for qualifying members to receive medically necessary transportation services. NEMT services are authorized under SSA Section 1902 (a)(70), 42 CFR Section 440.170, and Title 22 of the California Code of Regulations (CCR) Sections 51323, 51231.1, and 51231.2.

AB 2394 amended WIC Section 14132(ad)(1) to provide that, effective July 1, 2017, NMT is covered, subject to utilization controls and permissible time and distance standards, for MCP members to obtain covered Medi-Cal medical, dental, mental health, and substance use disorder services. Beginning on July 1, 2017, MCPs must provide NMT for MCP members to obtain medically necessary MCP-covered services and must make their best effort to refer for and coordinate NMT for all Medi-Cal services

[1] CMS-2333-F

not covered under the MCP contract. Effective October 1, 2017, in part to comply with CMS-2333-F and to have a uniform delivery system, MCPs must also provide NMT for Medi-Cal services that are not covered under the MCP contract. Services that are not covered under the MCP contract include, but are not limited to, specialty mental health, substance use disorder, dental, and any other services delivered through the Medi-Cal fee-for-service (FFS) delivery system.

REQUIREMENTS:

Non-Emergency Medical Transportation
NEMT services are a covered Medi-Cal benefit when a member needs to obtain medically necessary covered services and when prescribed in writing by a physician, dentist, podiatrist, or mental health or substance use disorder provider. NEMT services are subject to a prior authorization, except when a member is transferred from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a skilled nursing facility or an intermediate care facility licensed pursuant to Health and Safety Code (HSC) Section 1250[2].

MCPs must ensure that the medical professional's decisions regarding NEMT are unhindered by fiscal and administrative management, in accordance with their contract with DHCS[3]. MCPs are also required to authorize, at a minimum, the lowest cost type of NEMT transportation (see modalities below) that is adequate for the member's medical needs. For Medi-Cal services that are not covered by the MCP's contract, the MCP must make its best effort to refer for and coordinate NEMT. MCPs must ensure that there are no limits to receiving NEMT as long as the member's medical services are medically necessary and the NEMT has prior authorization.

MCPs are required to provide medically appropriate NEMT services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for obtaining medically necessary services[4]. MCPs are required to provide NEMT for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches[5]. MCPs shall also ensure door-to-door assistance for all members receiving NEMT services.

Unless otherwise provided by law, MCPs must provide transportation for a parent or a guardian when the member is a minor. With the written consent of a parent or guardian, MCPs may arrange NEMT for a minor who is unaccompanied by a parent or a guardian.

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[2] 22 CCR Section 51323 (b)(2)(C)
[3] Exhibit A, Attachment 1 (Organization and Administration of the Plan)
[4] 22 CCR Section 51323 (a)
[5] Manual of Criteria for Medi-Cal Authorization, Chapter 12.1 Criteria for Medical Transportation and Related Services

MCPs must provide transportation services for unaccompanied minors when applicable State or federal law does not require parental consent for the minor's service. The MCP is responsible to ensure all necessary written consent forms are received prior to arranging transportation for an unaccompanied minor.

MCPs must provide the following four available modalities of NEMT transportation in accordance with the Medi-Cal Provider Manual[6] and the CCR[7] when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for the purpose of obtaining needed medical care:

1. MCPs must provide **NEMT ambulance services** for[8]:
    - Transfers between facilities for members who require continuous intravenous medication, medical monitoring or observation.
    - Transfers from an acute care facility to another acute care facility.
    - Transport for members who have recently been placed on oxygen (does not apply to members with chronic emphysema who carry their own oxygen for continuous use).
    - Transport for members with chronic conditions who require oxygen if monitoring is required.

2. MCPs must provide **litter van services** when the member's medical and physical condition does not meet the need for NEMT ambulance services, but meets both of the following:
    - Requires that the member be transported in a prone or supine position, because the member is incapable of sitting for the period of time needed to transport[9].
    - Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance[10].

3. MCPs must provide **wheelchair van services** when the member's medical and physical condition does not meet the need for litter van services, but meets any of the following:
    - Renders the member incapable of sitting in a private vehicle, taxi or other form of public transportation for the period of time needed to transport[11].

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[6] Medi-Cal Provider Manual: Medical Transportation – Ground
[7] 22 CCR Section 51323(a) and (c)
[8] Medi-Cal Provider Manual: Medical Transportation – Ground, page 9, Ambulance: Qualified Recipients
[9] 22 CCR Section 51323 (2)(A)(1)
[10] 22 CCR Section 51323 (2)(B)
[11] 22 CCR Section 51323 (3)(A)

- Requires that the member be transported in a wheelchair or assisted to and from a residence, vehicle and place of treatment because of a disabling physical or mental limitation[12].
- Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance[13].

Members with the following conditions may qualify for wheelchair van transport when their providers submit a signed Physician Certification Statement (PCS) form (as described below)[14]:

- Members who suffer from severe mental confusion.
- Members with paraplegia.
- Dialysis recipients.
- Members with chronic conditions who require oxygen but do not require monitoring.

4. MCPs must provide **NEMT by air** only under the following conditions[15]:
   - When transportation by air is necessary because of the member's medical condition or because practical considerations render ground transportation not feasible. The necessity for transportation by air shall be substantiated in a written order of a physician, dentist, podiatrist, or mental health or substance use disorder provider.

NEMT Physician Certification Statement Forms

MCPs and transportation brokers must use a DHCS approved PCS form to determine the appropriate level of service for Medi-Cal members. Once the member's treating physician prescribes the form of transportation, the MCP cannot modify the authorization. In order to ensure consistency amongst all MCPs, all NEMT PCS forms must include, at a minimum, the components listed below:

- Function Limitations Justification: For NEMT, the physician is required to document the member's limitations and provide specific physical and medical limitations that preclude the member's ability to reasonably ambulate *without* assistance or be transported by public or private vehicles.
- Dates of Service Needed: Provide start and end dates for NEMT services; authorizations may be for a maximum of 12 months.
- Mode of Transportation Needed: List the mode of transportation that is to be used when receiving these services (ambulance/gurney van, litter van, wheelchair van or air transport).

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[12] 22 CCR Section 51323 (3)(B)
[13] 22 CCR Section 51323 (3)(C)
[14] Medi-Cal Provider Manual: Medical Transportation – Ground, page 11, Wheelchair Van
[15] 22 CCR Section 51323 (c)(2)

- Certification Statement: Prescribing physician's statement certifying that medical necessity was used to determine the type of transportation being requested.

Each MCP must have a mechanism to capture and submit data from the PCS form to DHCS. Members can request a PCS form from their physician by telephone, electronically, in person, or by another method established by the MCP.

Non-Medical Transportation
NMT has been a covered benefit when provided as an EPSDT service[16]. Beginning on July 1, 2017, MCPs must provide NMT for MCP members to obtain medically necessary MCP-covered services. For all Medi-Cal services not covered under the MCP contract, MCPs must make their best effort to refer for and coordinate NMT.

Effective October 1, 2017, MCPs must provide NMT for all Medi-Cal services, including those not covered by the MCP contract. Services that are not covered under the MCP contract include, but are not limited to, specialty mental health, substance use disorder, dental, and any other benefits delivered through the Medi-Cal FFS delivery system.

NMT does not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances, litter vans, or wheelchair vans licensed, operated, and equipped in accordance with state and local statutes, ordinances, or regulations. Physicians may authorize NMT for members if they are currently using a wheelchair but the limitation is such that the member is able to ambulate without assistance from the driver. The NMT requested must be the least costly method of transportation that meets the member's needs.

MCPs are contractually required to provide members with a Member Services Guide that includes information on the procedures for obtaining NMT transportation services[17]. The Member Services Guide must include a description of NMT services and the conditions under which NMT is available.

At a minimum, MCPs must provide the following NMT services[18]:

- Round trip transportation for a member by passenger car, taxicab, or any other form of public or private conveyance (private vehicle)[19], as well as mileage reimbursement for medical purposes[20] when conveyance is in a private vehicle arranged by the member and not through a transportation broker, bus passes, taxi vouchers or train tickets.

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[16] WIC 14132 (ad)(7)
[17] Exhibit A, Attachment 13 (Member Services), Written Member Information
[18] WIC Section 14132(ad)
[19] Vehicle Code (VEH) Section 465
[20] IRS Standard Mileage Rate for Business and Medical Purposes

- Round trip NMT is available for the following:
    - Medically necessary covered services.
    - Members picking up drug prescriptions that cannot be mailed directly to the member.
    - Members picking up medical supplies, prosthetics, orthotics and other equipment.
- MCPs must provide NMT in a form and manner that is accessible, in terms of physical and geographic accessibility, for the member and consistent with applicable state and federal disability rights laws.

Conditions for Non-Medical Transportation Services:

- MCP may use prior authorization processes for approving NMT services and re-authorize services every 12 months when necessary.
- NMT coverage includes transportation costs for the member and one attendant, such as a parent, guardian, or spouse, to accompany the member in a vehicle or on public transportation, subject to prior authorization at time of initial NMT authorization request.
- With the written consent of a parent or guardian, MCPs may arrange for NMT for a minor who is unaccompanied by a parent or a guardian. MCPs must provide transportation services for unaccompanied minors when state or federal law does not require parental consent for the minor's service. The MCP is responsible to ensure all necessary written consent forms are received prior to arranging transportation for an unaccompanied minor.
- NMT does not cover trips to a non-medical location or for appointments that are not medically necessary.
- For private conveyance, the member must attest to the MCP in person, electronically, or over the phone that other transportation resources have been reasonably exhausted. The attestation may include confirmation that the member:
    - Has no valid driver's license.
    - Has no working vehicle available in the household.
    - Is unable to travel or wait for medical or dental services alone.
    - Has a physical, cognitive, mental, or developmental limitation.

Non-Medical Transportation Private Vehicle Authorization Requirements

The MCPs must authorize the use of private conveyance (private vehicle)[21] when no other methods of transportation are reasonably available to the member or provided by the MCP. Prior to receiving approval for use of a private vehicle, the member must exhaust all other reasonable options and provide an attestation to the MCP stating other methods of transportation are not available. The attestation can be made over the

[21] VEH Section 465

phone, electronically, or in person. In order to receive gas mileage reimbursement for use of a private vehicle, the driver must be compliant with all California driving requirements, which include[22]:

- Valid driver's license.
- Valid vehicle registration.
- Valid vehicle insurance.

MCPs are only required to reimburse the driver for gas mileage consistent with the Internal Revenue Service standard mileage rate for medical transportation[23].

Non-Medical Transportation Authorization
MCPs may authorize NMT for each member prior to the member using NMT services. If the MCP requires prior authorization for NMT services, the MCP is responsible for developing a process to ensure that members can request authorization and be approved for NMT in a timely matter. The MCP's prior authorization process must be consistently applied to medical/surgical, mental health and substance use disorder services as required by CMS-2333-F.

Non-Medical Transportation and Non-Emergency Medical Transportation Access Standards
MCPs are contractually required to meet timely access standards[24]. MCPs that have a Knox-Keene license are also required to meet the timely access standards contained in Title 28 CCR Section 1300.67.2.2. The member's need for NMT and NEMT services do not relieve the MCPs from complying with their timely access standard obligations.

MCPs are responsible for ensuring that their delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contractual requirements, and other requirements set forth in DHCS guidance, including APLs and Dual Plan Letters. MCPs must timely communicate these requirements to all delegated entities and subcontractors in order to ensure compliance.

[22] VEH Section 12500, 4000, and 16020
[23] IRS Standard Mileage Rate for Business and Medical Purposes
[24] 28 CCR Section1300.51(d)(H); Exhibit A, Attachment 9 (Access and Availability)

If you have any questions regarding this APL, contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division