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## Payment for Medi-Cal Emergency and Post-Stabilization Mental Health Services

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*The information, statements and recommendations in this document are general in nature, do not constitute legal advice, and should not be used as a substitute for obtaining competent legal counsel. This guidance is provided by CHA to help its member hospitals better understand their rights and responsibilities arising from relationships with health plans and other managed care entities for Medi-Cal emergency mental health services. Readers should be aware that the laws, rules and regulatory guidance are subject to change. CHA encourages its members to contact legal counsel for legal advice regarding billing and disputes between a hospital and a MCP or MHP. In developing this guidance for its members, CHA seeks to educate its members about the law that apply to Medi-Cal coverage for emergency mental health services. It is not CHA's intent to engage in any form of concerted activity by publishing this guidance.*

# Payment for Medi-Cal Emergency and Post-Stabilization Mental Health Services

## I. Introduction

*Consider this scenario: A Medi-Cal patient presents to a hospital's emergency department (ED) complaining of chest pain. The hospital does not have an inpatient psychiatric unit. The hospital provides a medical screening exam and further evaluation and treatment; cardiac conditions are ruled out. The patient is diagnosed with a severe anxiety disorder. The patient's anxiety disorder is treated and the patient is discharged home.*

*Question: Who is responsible for paying for the services rendered to rule out cardiac conditions? Who is responsible for paying for the services rendered to diagnose and treat the mental health conditions?*

California hospitals struggle with situations like this every day, trying to determine who is responsible for paying for the various services rendered – those related to “physical health” conditions, and those related to mental health conditions. Does the hospital bill the Medi-Cal managed care plan (MCP) only? Or the county mental health plan (MHP) only? Both the MCP and the MHP for different services rendered? Or do other factors affect the analysis? What can the hospital do when both the MHP and MCP deny financial responsibility?

This guidance analyzes the various and sometimes conflicting laws governing who is responsible to pay for services rendered in an ED to Medi-Cal patients with mental health conditions.

## A. Background

The State of California administers the Medi-Cal program through the Department of Health Care Services (DHCS). DHCS contracts with both MCPs and MHPs to serve Medi-Cal patients. MCPs provide care for the patients' physical conditions as well as for specified, lower-acuity mental health conditions.<sup>1</sup> Because counties have historically played an important role in providing access to mental health services for Medi-Cal beneficiaries, DHCS delegates payment for other mental health services to MHPs.

However, due to the various co-morbidities associated with mental health patients, the line delineating payment responsibility between MCPs and MHPs is often blurred. For example, when a patient presents with multiple diagnoses, especially both mental and physical in nature, both a MCP and MHP may be responsible for payment.<sup>2</sup>

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<sup>1</sup> This guidance focuses on the typical allocation of payment responsibilities between MCPs and MHPs in California. Certain counties, such as Solano County, and plans, such as Kaiser geographic managed care, are different and not the focus of this guidance. This guidance also does not focus on the responsibility of other types of managed care, such as PACE programs, SCAN programs or the San Francisco Family Mosaic Project.

<sup>2</sup> For example, this guidance does not attempt to give a definitive answer to the scenario described in the first paragraph; rather, the responsibility for payment in this scenario should be reviewed in the discussion of Scenarios 1 and 2 in Section III.

While reading this guidance, it's important to keep in mind that the federal Emergency Medical Treatment and Labor Act and state licensing requirements to provide emergency services to psychiatric patients, are different from the Medi-Cal requirements to pay for those services. As a result, hospitals are often not reimbursed for all the services they're required to provide.

Hospitals should know that MHPs are not licensed under the Knox-Keene Health Care Service Plan Act, and are not regulated by the California Department of Managed Health Care (DMHC). Most MCPs are licensed under the Knox-Keene Act and are regulated by DMHC, except for county operated health systems with respect to their Medi-Cal lines of service.

## **B. Scope of This Guidance**

This guidance reviews the laws and DHCS interpretations about payment for ED services, including emergency medical services, emergency psychiatric services, and non-emergency services. This guidance also provides some arguments that may help hospitals obtain improved reimbursement for mental health services rendered to Medi-Cal patients presenting to the ED with a mental health condition.

Due to the complexities of reimbursement for mental health conditions, this guidance is not fully comprehensive. For example, this guidance does not address the memoranda of understanding (MOU) that DHCS requires between MCPs and MHPs to coordinate mental health services for Medi-Cal patients.<sup>3</sup> Also, this guidance does not address coordination of benefits between Medi-Cal and other health coverage, e.g., where a Medi-Cal patient has private insurance, or is enrolled in Medi-Cal managed care and Medicare fee-for-service or Medicare Advantage, or for a patient enrolled in a Cal MediConnect plan. Nor does this guidance address payment responsibility for a patient who is enrolled in Medi-Cal fee-for-service instead of Medi-Cal managed care. Hospitals may wish to seek separate guidance for these fact-specific issues.

This guidance is organized as follows:

**Section II – Medi-Cal Payment for Mental Health Services.** Section II describes the mental health services covered by MHPs (Subsection 1) and MCPs (Subsection 2); the respective obligations of MHPs and MCPs to pay for emergency and post-stabilization services rendered by non-contracted providers; and coordination of payment and care management between MHPs and MCPs.

**Section III – How Hospitals Can Get Reimbursed: A Case-by-Case Analysis.** Section III applies the general payment principles described in Section II to eight scenarios where a patient presents to an ED with a complaint that includes a psychiatric condition.

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<sup>3</sup> Boilerplate MCP Contract, Exh. A, Attachment 11, Provision 6.B, available at <http://www.dhcs.ca.gov/provgovpart/Documents/ImpRegSB2PlanBp32014.pdf>. Citations to the boilerplate contracts are to the two plan model contracts, but parallel provisions are found in the county operated health system and geographic managed care model boilerplate contracts.

If an MOU is not posted on the MCP or MHP's website and is not readily available upon request from the MCP, MHP or county behavioral health department, a hospital may make a formal request for it under the California Public Records Act.

**Appendix A.** This appendix contains the state regulations describing medical necessity for MHP coverage of psychiatric inpatient, emergency and outpatient specialty mental health services.

**Appendix B.** This appendix briefly describes the types of MCPs and MHPs throughout the state and their governing authorities.

**Appendix C.** This appendix contains excerpts of DHCS plan letters related to emergency services for mental health conditions.

**Appendix D.** This appendix contains a DHCS chart describing mental health services for Medi-Cal patients.

**Appendix E.** This appendix compares Medicaid, Medi-Cal, licensing and EMTALA definitions that apply to emergency psychiatric conditions.

## **II. Medi-Cal Payment for Mental Health Services**

### **A. What mental health services are covered by MHPs?**

The state contracts with a MHP in each county to provide or arrange for, and pay for, all medically necessary, covered Specialty Mental Health Services (SMHS) for Medi-Cal patients who reside in that county.<sup>4</sup> “Covered SMHS” means specified health services, including psychiatric health facility services, that meet the criteria for “medical necessity” set forth in MHP regulations at Title 9, California Code of Regulations (CCR) Sections 1820.205, 1830.205 or 1830.210. The criteria are outlined in Appendix A. Many counties have informational documents on their website which may be helpful to hospitals. (See [http://www.file.lacounty.gov/SDSInter/dmh/159129\\_MediCalGuide\\_English\\_July2013.pdf](http://www.file.lacounty.gov/SDSInter/dmh/159129_MediCalGuide_English_July2013.pdf) for an example.)

The state contractually requires MHPs to pay for “services for emergency psychiatric conditions received by a beneficiary from providers, whether or not the provider has a subcontract” with the MHP.<sup>5</sup> The contract between the state and the MHP does not define the term “emergency psychiatric condition,” but requires the MHP to consider certain ICD-9 diagnosis codes as included. While not defined in the contract, the term “emergency psychiatric condition” is defined in Title 9, CCR Section 1810.216 as a condition meeting the medical necessity criteria in Title 9, CCR, Section 1820.205 when the patient, “due to a mental disorder, is a current danger to self or others, or immediately unable to provide for or utilize, food, shelter or clothing, and requires psychiatric inpatient hospital or psychiatric health facility services.”<sup>6</sup> Unfortunately,

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<sup>4</sup> Boilerplate MHP Contract, Exh. A, Attachment I, available at [http://www.dhcs.ca.gov/services/MH/Documents/2013-2018\\_MHP\\_Contract.pdf](http://www.dhcs.ca.gov/services/MH/Documents/2013-2018_MHP_Contract.pdf).

<sup>5</sup> Boilerplate MHP Contract, Exh. A, Attachment I, provision 3.

<sup>6</sup> As shown in Appendix E, the definition of “emergency psychiatric condition” in the MHP regulations varies from the definition of “psychiatric emergency medical condition” in the California emergency services licensing laws (Health & Safety Code Section 1317.1). The licensing laws, which govern the emergency care that a hospital must provide, do not require “medical necessity” or that a hospital maintain a psychiatric service,

there is little explanation in the contract, the regulations or other guidance that details the precise parameters of the MHP's obligation to cover services for emergency psychiatric conditions.

California regulations also require a MHP to cover services rendered when a patient with an emergency psychiatric condition is admitted for psychiatric inpatient hospital services to the extent provided in Title 9, CCR Section 1820.225 (an "emergency admission") or admitted for psychiatric health facility services under the conditions described in Title 9, CCR Section 1830.245, whether in-network or out-of-network. Approval for payment for such services associated with an emergency psychiatric condition may be subject to the patient meeting certain medical necessity and other criteria, as well as timely notification by the hospital or psychiatric health facility to the MHP.<sup>7</sup>

DHCS has issued several plan letters, including Medi-Cal Managed Care Policy Letter (MMCD) 00-01 and All Plan Letter (APL) 13-021, excerpts of which are included in Appendices C and D, respectively. These DHCS documents attempt to clarify when the MCP is responsible for payment, and when the MHP is responsible for payment, but the documents are not entirely consistent. However, based on these letters, it is likely DHCS' position that the MHP is responsible for the following emergency, inpatient and outpatient services:

Emergency/inpatient services if the patient:

1. Has an included diagnosis;
2. Cannot be safely treated at lower level of care; and
3. Requires inpatient hospital services due to one of the following as a result of an included mental disorder:
  - (a) Symptoms or behaviors that represent a current danger to self or others, or significant property destruction;
  - (b) Symptoms or behaviors that prevent the beneficiary from providing for, or utilizing, food, clothing, or shelter;
  - (c) Symptoms or behaviors that present a severe risk to the beneficiary's physical health;
  - (d) Symptoms or behaviors that represent a recent, significant deterioration in ability to function;
  - (e) Psychiatric evaluation or treatment can only be performed in an acute psychiatric inpatient setting or through urgent or emergency intervention provided in the community or clinic; and

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in order for a psychiatric condition to be deemed an "emergency condition" that the hospital must treat or effectuate a transfer.

<sup>7</sup> Title 9, CCR Sections 1820.225 and 1830.245.

(f) Serious adverse reactions to medications, procedures or therapies requiring continued hospitalization.<sup>8</sup>

Facility charges for emergency services when the patient meets medical necessity criteria and is admitted for psychiatric inpatient services at the same facility that provided the emergency services.<sup>9</sup>

Facility charges directly related to the professional services of a mental health specialist provided in the ED when the services do not result in the patient's admission for psychiatric inpatient hospital services in the same or another facility.<sup>10</sup>

Professional services of a mental health specialist provided in an ED of any hospital to a patient whose condition meets medical necessity criteria or when required to assess whether medical necessity is met.<sup>11</sup>

- Outpatient services if:
  1. The patient has an included mental health diagnosis;
  2. The patient has a significant impairment in an important area of life function, or a reasonable probability of deterioration in an important area of life function, or a reasonable probability of not progressing developmentally as individually appropriate;
  3. The focus of treatment is to address impairment;
  4. The expectation that proposed treatment will significantly diminish impairment, prevent significant deterioration; and
  5. The condition would not be responsive to physical health care-based treatment.<sup>12</sup>

## **B. What mental health services are covered by MCPs?**

The state contracts with MCPs to provide or arrange for medically necessary covered services for Medi-Cal patients assigned to them, including outpatient mental health services. "Outpatient mental health services" are defined as:

outpatient services that [the MCP] will provide for Members with mild to moderate mental health conditions including: individual or group mental health evaluation and treatment (psychotherapy); psychological testing when clinically

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<sup>8</sup> APL 13-021.

<sup>9</sup> Medi-Cal Managed Care Policy Letter (MMCD) 00-01.

<sup>10</sup> *Id.*

<sup>11</sup> *Id.*

<sup>12</sup> *Id.*

indicated to evaluate a mental health condition; psychiatric consultation for medication management; and outpatient laboratory, supplies, and supplements.<sup>13</sup>

SMHS are excluded from the scope of MCP services.<sup>14</sup>

MCPs are required to pay for certain medically necessary mental health services, such as “[e]mergency room professional services as described in Title 22, CCR Section 53855, except services provided by psychiatrists, psychologists, licensed clinical social workers, marriage, family and child counselors [now called marriage and family therapists], or other specialty mental health providers” and “[f]acility charges for emergency room visits which do not result in a psychiatric admission.”

DHCS has stated that the MHP is responsible for the following emergency and outpatient services:

- Emergency Services:
  - All professional services except the professional services of a mental health specialist when required for the emergency services and care of a patient, regardless of whether the condition meets MHP medical necessity criteria<sup>15</sup>; and
  - All facility and professional charges for emergency services and care of a patient when such services do not result in admission. This includes patients with an excluded diagnosis or whose condition does not meet medical necessity criteria.<sup>16</sup>
  
- Outpatient Services:
  - When the patient has been diagnosed with a mental health disorder as defined by the DSM<sup>17</sup> resulting in mild to moderate distress or impairment of mental, emotional or behavioral functioning.<sup>18</sup>

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<sup>13</sup> Boilerplate MCP Contract, Exh. E, Attachment 1.

<sup>14</sup> Boilerplate MCP Contract, Exh. A, Attachment 11, Provision 6.

<sup>15</sup> MMCD 00-01.

<sup>16</sup> MMCD 00-01; *see also* Dual Plan Letter 15-006, p. 5.

<sup>17</sup> “DSM” refers to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, DSM-IV (1994), published by the American Psychiatric Association.

<sup>18</sup> APL 13-021.

### **C. Must MHPs and MCPs pay for emergency and post-stabilization services rendered by non-contracted providers?**

- Emergency Services:

Under federal Medicaid law, the contracts between the state and MCPs/MHPs, and the waivers governing the MCP and MHP programs,<sup>19</sup> MCPs and MHPs are required to pay for emergency services and post-stabilization services regardless of whether the provider has a contract with the plan.<sup>20</sup> The Centers for Medicare & Medicaid Services (CMS) has stated that this obligation applies only if the patient has an “emergency medical condition” as defined below.

If a psychiatric condition does not give rise to an “emergency medical condition” within the definition below — that is, there is no risk of serious jeopardy to the health of the patient — then the patient is not considered to have an emergency medical condition under federal law and the MCP or MHP is not required to pay.<sup>21</sup> However, DHCS has suggested that the scope of emergency services required to be covered under California law may expand to “screening, examination, and evaluation to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric medical condition, within the capability of the facility.”<sup>22</sup>

Federal Medicaid law defines an emergency medical condition as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. [42 C.F.R. Section 422.113(b)(1)(i)<sup>23</sup>]

Emergency services are defined as covered inpatient and outpatient services that are rendered by a provider qualified to furnish emergency services; and needed to evaluate or stabilize an emergency medical condition. [42 C.F.R. Section 422.113(b)(1)(ii)]

- Post-Stabilization Services:

Federal Medicaid law defines “post-stabilization services” as covered services that are related to an emergency medical condition; provided after an enrollee is stabilized; and

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<sup>19</sup> The MHP program is governed by the 1915(b) waiver while the MCP program is governed by the 1115 waiver. These citations are to the sections of the Social Security Act authorizing the waivers.

<sup>20</sup> 2 U.S.C. Section 1396u-2(b)(2); 42 C.F.R. Section 438.114(c); Title 9, CCR Section 1810.345(e); Boilerplate MHP Contract, Exh. A, Attachment I, provision 3; Boilerplate MCP Contract, Exh. A, Attachment 8, Provision 13.

<sup>21</sup> 67 Fed. Reg. 40989, 41030 (June 14, 2002).

<sup>22</sup> MCD Policy Letter No. 00-01 Rev., excerpted in Appendix C.

<sup>23</sup> See Paragraph D below as to variances in the definition of “emergency medical condition” in the federal Medicaid law and in the federal EMTALA regulations (42 C.F.R. Section 489.24(b)).

provided either to maintain the stabilized condition, or under certain circumstances, to improve or resolve the enrollee's condition.<sup>24</sup> The physician treating the enrollee must decide when the enrollee is considered stabilized for transfer or discharge, and that decision is binding on an MCP or MHP.<sup>25</sup>

Under the federal Medicaid regulations, a MCP or MHP is financially responsible for post-stabilization services obtained within, or outside, the plan network that meet one of the following:

- Are pre-approved by a plan provider or other plan representative; or
- Are not pre-approved by a plan provider or other plan representative, but are administered to maintain the patient's stabilized condition within one hour of a request to the plan for pre-approval of further post-stabilization care; or
- Are not pre-approved by a plan provider or other plan representative, but administered to maintain, improve, or resolve the patient's stabilized condition if:
  - The plan does not respond to a request for pre-approval within one hour;
  - The plan cannot be contacted; or
  - The plan representative and the treating physician cannot reach an agreement concerning the patient's care, and a plan physician is not available for consultation. In this situation, the plan must give the treating physician the opportunity to consult with a plan physician. The treating physician may continue with care of the patient until a plan physician is reached or one of the criteria below is met.<sup>26</sup>

If no pre-approval has been obtained, the MCP or MHP's financial responsibility for post-stabilization services ends when one of the following has occurred:

- A plan physician with privileges at the treating hospital assumes responsibility for the patient's care; or
- A plan physician assumes responsibility for the patient's care through transfer; or
- A MCP or MHP plan representative and the treating physician reach an agreement concerning the patient's care; or
- The patient is discharged.<sup>27</sup>

In summary, covered psychiatric emergency services apply to the extent that a mental health diagnosis is such that a prudent layperson could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part, inpatient and outpatient services needed to evaluate or stabilize the condition would constitute covered emergency services. Covered post-stabilization psychiatric services apply to services provided after the

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<sup>24</sup> 42 C.F.R. Section 422.113(c)(1).

<sup>25</sup> 42 C.F.R. Section 422.113(b)(3).

<sup>26</sup> 42 C.F.R. Section 422.113(c)(2).

<sup>27</sup> 42 C.F.R. Section 422.113(c)(3).

patient's psychiatric condition is stabilized in order to maintain the stabilized condition or to improve or resolve the enrollee's condition.

**D. Do the terms “emergency medical condition” and “psychiatric emergency medical condition” for Medi-Cal reimbursement purposes have the same definition as these terms are applied under EMTALA or state licensing laws for emergency psychiatric medical conditions?**

No. As shown in Appendix E, the definition of “emergency medical condition” in the federal Medicaid law (42 U.S.C. Section 1396u-2(b)(2)(C)) varies from the definition of “emergency medical condition” in the federal EMTALA regulations (42 C.F.R. Section 489.24(b)). The EMTALA regulations explicitly include “psychiatric disturbances” and “symptoms of substance abuse” in the definition of “emergency medical condition”: “a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to” jeopardize the health of the patient. The federal Medicaid law does not mention psychiatric disturbances.

The mental health parity law (42 U.S.C. Section 300gg) requires a Medicaid managed care plan to provide out-of-network benefits for mental health/substance use disorders if it provides out-of-network benefits for medical/surgical conditions. However, this requirement is applied across a state's Medicaid program, and does not mean that the same plan that might be liable for the medical/surgical benefit is necessarily liable for the mental health/substance use benefit.<sup>28</sup>

At the state level, the definition of “psychiatric emergency medical condition” in the MHP regulations varies from the definition of “psychiatric emergency medical condition” in the California emergency services licensing law (Health & Safety Code Section 1317.1). The MHP regulations require “medical necessity” and psychiatric hospital services in order for the psychiatric condition to be deemed an “emergency condition.” The licensing definition does not impose either requirement for a psychiatric condition to be deemed an emergency condition.

It is noted that all of the definitions of “emergency medical condition” and “psychiatric emergency medical condition” apply when the patient may be a danger to himself/herself, which may include grave disability; however, the Medicaid definition does not include a situation where a patient may be a danger to others but not to himself/herself.

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<sup>28</sup> 42 C.F.R. Section 438.920(b).

## **E. How do MHPs and MCPs coordinate their payment and care management obligations?**

MCPs and MHPs are required to execute memoranda of understanding (“MOUs”) to coordinate care between them.<sup>29</sup> There have been over 100 MOUs executed in the State of California.<sup>30</sup> Each MOU should include the following topics:

- Basic requirements
- Covered services and populations
- Oversight responsibilities of the MCP and MHP
- Screening, assessment and referral
- Care coordination,
- Information exchange
- Reporting and quality improvement requirements
- Dispute resolution
- After-hours policies and procedures and
- Member and provider education.

However, the National Health Law Program study cited in footnote 31 reported that many MOUs fail to include some of these required topics.<sup>31</sup>

Review of a MOU may help a hospital understand how its local MCP and MHP have agreed to coordinate care, including screening, assessment and referral of ED patients. Accordingly, hospitals may wish to review their local MOU(s) in connection with their review of the analysis in this guidance, which does not include any analysis of the MOUs across the state. Hospitals may be able to rely on promises from MCPs and MHPs to each other in order to effectuate better care coordination for patients who present at their ED with mental health conditions.

If a MOU is not available on the internet, a hospital may wish to request a copy of the agreement from the MHP pursuant to the California Public Records Act.

## **III. How Hospitals Can Get Reimbursed: A Case-by-Case Analysis**

CHA has applied the general principles of the various laws and DHCS interpretations described above to the following eight scenarios to help hospitals identify which type of plan likely is responsible for reimbursing the hospital for emergency psychiatric services. However, individual circumstances may affect the outcome of each scenario. For example, a contract between a hospital and a specific plan may set forth the payment responsibilities by that plan to the hospital. If there is no contract between a hospital and a specific plan, the facts, such as

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<sup>29</sup> Title 9, CCR Sections 1810.370, 1810.415, 1850.505, 1850.515, 1850.525; MCP Boilerplate Contracts, Exh. A, Attachment 11 and Attachment 12; All Plan Letter 13-018.

<sup>30</sup> Lewis, K. and Coursolle, A., National Health Law Program, Mental Health Services in Medi-Cal, p. 7 (Jan. 12, 2017).

<sup>31</sup> *Id.*

whether notice of stabilization was given or whether the plan pre-approved the care, will determine whether there may be an implied contract between the hospital and the plan.

Each scenario below begins with a patient presenting to a hospital ED, either voluntarily or involuntarily. However, the scenarios differ as to whether the hospital has inpatient psychiatric beds, whether the patient has a psychiatric emergency condition, whether the patient’s psychiatric condition is stabilized in the ED, whether the patient is stabilized when admitted to a psychiatric inpatient bed, whether the patient is transferred to an inpatient psychiatric facility, whether the patient is actually admitted to a psychiatric inpatient bed and whether the patient is discharged to the community.<sup>32</sup>

Scenario #	Hospital ED	Hospital w/Psych Inpt.	Pt. has Psych Emergency <sup>33</sup>	Stabilized in ED	Transferred to Psych Inpt.	Admitted to Psych Inpt.	Final Status
1	Yes	Either	Yes	Yes	No	No	Discharged to community
2	Yes	Either	No	NA	No	No	Discharged to community
3.a	Yes	Yes	Yes	Possible	Yes	No	Transferred to another hospital
3.b	NA	Yes	Yes	Possible	No	Yes	Admitted
4	Yes	Yes	Yes	No	No	Yes	Admitted
5.a	Yes	No	Yes	Sufficient for transfer	Yes	See 5.b.1/5.b.2	Transferred to another hospital
5.b.1	NA	Yes	Yes	Received transfer	No	Yes	Admitted
5.b.2	NA	Yes	Yes	Received transfer	No	No	Discharged to community

Each scenario assumes that the patient is given a medical screening examination to assess the emergent nature of the patient’s medical or psychiatric condition. In most instances, the MCP is likely responsible to pay for the medical screening examination.

**Scenario 1: Patient presents at the ED of a hospital with or without inpatient psychiatric services. The patient is experiencing depression and suicidal ideation. The patient is determined by a physician or other professional to have an emergency psychiatric condition. The patient’s psychiatric condition is stabilized in the ED after a licensed clinical social worker consults with the patient and obtains information from family members about a recent break-up with a girlfriend. After several hours, the patient is discharged home with a referral for follow-up outpatient care.**

<sup>32</sup> The involvement or intervention in the emergency services process by county-designated mental health professionals does not affect which plan is responsible for payment.

<sup>33</sup> In other words, the patient is determined by a physician or other professional to have an emergency psychiatric condition within the meaning of EMTALA and the California hospital licensing laws (Health & Safety Code Section 1317.1).

This patient required a level of care that did not require an acute inpatient stay. Accordingly, consistent with the MCP-State contract, MMCD 00-01 and APL 13-021, it is likely that the MCP is responsible for paying for the ED visit, including both the facility and professional charges. The MCP will not pay for services provided by mental health specialists, such as the consult with the LCSW.<sup>34</sup> Instead, it is the MHP's responsibility to pay for the professional services of mental health specialists provided in the ED to patients meeting MHP medical necessity criteria or required to assess whether MHP criteria are met, and any facility charges directly related to mental health specialists' services.<sup>35</sup> It is likely that the MCP is responsible for mental health specialists' services required for the emergency services and care of a patient with an excluded diagnosis. Hospitals should have a billing policy in place to ensure that facility fees are not inadvertently collected from both the MHP and the MCP in those instances where both may be responsible for facility fees for professional services provided.

**Scenario 2: Patient presents at the ED of a hospital without inpatient psychiatric services. Although the patient is experiencing auditory hallucinations, and it is determined by a physician or other professional that the patient has a psychiatric condition, the patient does not have an *emergency* psychiatric condition. The patient is provided further evaluation and treatment and is subsequently discharged without an inpatient admission.**

The analysis for this scenario is likely the same as Scenario 1 because the patient's condition and level of care did not require an acute inpatient stay.

**Scenarios 3.a and 3.b: Patient presents to the ED of a hospital with inpatient psychiatric services. The patient has suicidal ideation with a specific plan. The patient is determined by a physician or other professional to have an emergency psychiatric condition, and is transferred to another facility that provides acute inpatient psychiatric services due to its lack of capacity or capability to admit the patient (e.g., transfer of an adolescent or child from a psychiatric facility that does not admit minors).**

*3.a. Sending hospital.* Both the MCP and the MHP may be responsible for reimbursement for hospital charges. More specifically, pursuant to the MMCD 00-01, the MCP may be responsible for facility charges incurred by the sending hospital. However, because the patient's condition ultimately resulted in a psychiatric admission and because the service was "for an emergency psychiatric condition," the MHP may also be responsible for the facility charges for services rendered by the sending hospital to the extent that the patient meets the medical necessity criteria. Hospitals may wish to review their contracts with the local MHP or MCP (if applicable) or the MOU between their local MHP and MCP for further clarification. Some MOUs have a gap where: (1) patients that are admitted at the same hospital are the responsibility of the MHP, (2) patients that are not admitted for inpatient psychiatric services are the responsibility of the MCP, and (3) no provision identifies responsibility where the patient is admitted for inpatient psychiatric services at another facility.

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<sup>34</sup> Specialty mental health providers include psychiatrists, psychologists, licensed clinical social workers, and marriage and family therapists (previously called marriage, family and child counselors).

<sup>35</sup> MMCD 00-01. This includes hospitals that provide and do not provide acute psychiatric services.

With respect to professional fees, the MHP likely is responsible for professional services of mental health specialists provided in the ED to patients meeting MHP medical necessity criteria or required to assess whether MHP criteria are met.<sup>36</sup> The MCP is likely responsible for other professional charges, including professional services not provided by mental health specialists and services provided by mental health specialists to patients who do not meet the medical necessity criteria.

*3.b. Receiving hospital.* Pursuant to the MHP-State contract and MMCD 00-01 and APL 13-021, the MHP is responsible for the inpatient acute psychiatric care rendered to this patient if the patient meets medical necessity criteria. The MCP continues to have responsibility for professional services necessary to meet the physical needs of the patient while admitted at the receiving hospital.<sup>37</sup> To the extent that the patient does not have a diagnosis listed in Appendix A but requires inpatient acute psychiatric care, the hospital should consult its legal counsel to pursue payment options for the services rendered.

**Scenario 4: Patient presents to the ED of a hospital with inpatient psychiatric services. The patient has suicidal ideation with a specific plan. The patient is determined by a physician or other professional to have an emergency psychiatric condition, and is admitted to the same hospital.**

Pursuant to the MHP-State contract and MMCD 00-01 and APL 13-021, if the patient meets the medical necessity criteria for MHP coverage, the MHP should be responsible for the care rendered to this patient. The emergency charges are likely to be incorporated into the reimbursement for the inpatient stay. However, the MCP may be responsible for professional services not rendered by a mental health specialist when required for the emergency services and care of the member.

If the patient does not have a diagnosis listed in Appendix A, the hospital should consult its legal counsel to pursue payment options for the services rendered.

**Scenarios 5.a, 5.b.1 and 5.b.2: Patient presents to the ED of a hospital that does not provide inpatient psychiatric services. The patient has suicidal ideation with a specific plan. The patient is determined by the ED physician or other professional to have an emergency psychiatric condition and is transferred to a hospital that provides inpatient psychiatric services, with the expectation of an admission.**

*5.a. Sending hospital.* Pursuant to the MMCD 00-01, the MCP may be responsible for facility charges incurred by the sending hospital. However, because the patient's condition may have required a psychiatric admission and because the service was "for an emergency psychiatric condition," the MHP may also be responsible for the facility charges for services rendered by the sending hospital to the extent that the patient meets the medical necessity criteria. Hospitals may wish to consult their contracts with their local MHP or MCP (if applicable) or the MOU between their local MHP and MCP for further clarification.

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<sup>36</sup> MMCD 00-01.

<sup>37</sup> MMCD 00-01.

With respect to professional services, the MHP is responsible for professional services of mental health specialists provided in the ED to patients meeting MHP medical necessity criteria or required to assess whether MHP criteria are met.<sup>38</sup> The MCP is likely responsible for other professional charges, including professional services not provided by mental health specialists and services provided by mental health specialists to patients who do not meet the medical necessity criteria.

*5.b.1. Receiving hospital that admits the patient.* Pursuant to the MHP-State contract and MMCD 00-01 and APL 13-021, the MHP is responsible for the inpatient psychiatric services rendered if the patient meets medical necessity criteria. The MCP continues to have responsibility for professional services necessary to meet the physical needs of the patient while admitted at the receiving hospital.<sup>39</sup> To the extent that the patient does not have a diagnosis listed in Appendix A but requires inpatient psychiatric care, the hospital may wish to consult its legal counsel to pursue payment options for the services rendered.

*5.b.2. Receiving hospital that does not admit the patient.* In some instances, the receiving hospital will determine that the patient does not require inpatient psychiatric care. In these cases, the payment responsibility for the services rendered by the receiving hospital should follow the rationale set forth in Scenarios 1 and 2.

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<sup>38</sup> MMCD 00-01.

<sup>39</sup> MMCD 00-01.

## Appendix A

<p><b>Title 9 CCR § 1820.205:</b> For MHP coverage as a <b>psychiatric inpatient service or an emergency psychiatric condition</b>, the patient must meet the following:</p>	
<p>Has one of the following diagnoses in the DSM-IVE:</p> <ul style="list-style-type: none"> <li>• Pervasive development disorders;</li> <li>• Disruptive behavior and attention deficit disorders;</li> <li>• Feeding and eating disorders of infancy or early childhood;</li> <li>• Tic disorders;</li> <li>• Elimination disorders;</li> <li>• Other disorders of infancy, childhood, or adolescence, cognitive disorders (dementia with delusions or depressed mood);</li> <li>• Substance induced disorders (with psychotic, mood, or anxiety disorder);</li> <li>• Schizophrenia and other psychotic disorders;</li> <li>• Mood disorders;</li> <li>• Anxiety disorders;</li> <li>• Somatoform disorders;</li> <li>• Dissociative disorders;</li> <li>• Eating disorders;</li> <li>• Intermittent explosive disorder;</li> <li>• Pyromania;</li> <li>• Adjustment disorders;</li> <li>• Personality disorders.</li> </ul>	<p>Cannot be safely treated at a lower level of care <u>and</u></p> <p>Requires psychiatric inpatient hospital services as the result of a mental disorder as the result of one of the following:</p> <ul style="list-style-type: none"> <li>• Has symptoms or behaviors due to a mental disorder that: <ul style="list-style-type: none"> <li>• Represent a current danger to self or others, or significant property destruction;</li> <li>• Prevent the beneficiary from providing for, or utilizing, food, clothing or shelter;</li> <li>• Present a severe risk to the beneficiary’s physical health; <u>or</u></li> <li>• Represent a recent, significant deterioration in ability to function.</li> </ul> </li> <li>• Requires admission for one of the following: <ul style="list-style-type: none"> <li>• Further psychiatric evaluation;</li> <li>• Medication treatment; <u>or</u></li> <li>• Other treatment that can reasonably be provided only if the patient is hospitalized.</li> </ul> </li> </ul>
<p><b>Title 9 CCR § 1830.205:</b> For MHP coverage for <b>outpatient specialty mental health services</b>, the patient and/or service must meet the following:</p>	
<p>Has one of the following diagnoses in the DSM-IVE:</p> <ul style="list-style-type: none"> <li>• Pervasive Developmental Disorders, except Autistic Disorders</li> <li>• Disruptive Behavior and Attention Deficit Disorders</li> <li>• Feeding and Eating Disorders of Infancy and Early Childhood</li> <li>• Elimination Disorders</li> <li>• Other Disorders of Infancy, Childhood, or Adolescence</li> </ul>	<p>Have one of the following impairments as a result of the mental disorder(s) on the left:</p> <ul style="list-style-type: none"> <li>• A significant impairment in an important area of life functioning</li> <li>• A reasonable probability of significant deterioration in an important area of life functioning</li> <li>• Except as provided in Section 1830.210, a reasonable probability a child will not progress developmentally as individually appropriate. For the purpose of this Section, a child is a person under the age of 21 years</li> </ul>

<ul style="list-style-type: none"> <li>• Schizophrenia and other Psychotic Disorders, except Psychotic Disorders due to a General Medical Condition</li> <li>• Mood Disorders, except Mood Disorders due to a General Medical Condition</li> <li>• Anxiety Disorders, except Anxiety Disorders due to a General Medical Condition</li> <li>• Somatoform Disorders</li> <li>• Factitious Disorders</li> <li>• Dissociative Disorders</li> <li>• Paraphilias</li> <li>• Gender Identity Disorder</li> <li>• Eating Disorders</li> <li>• Impulse Control Disorders Not Elsewhere Classified</li> <li>• Adjustment Disorders</li> <li>• Personality Disorders, excluding Antisocial Personality Disorder</li> <li>• Medication-Induced Movement Disorders related to other included diagnoses</li> </ul>	<p><u>and</u> the service meets each of the following criteria:</p> <ul style="list-style-type: none"> <li>• The focus of the proposed intervention is to address the condition identified in Subsection (b)(2) above.</li> <li>• The expectation is that the proposed intervention will: <ul style="list-style-type: none"> <li>• Significantly diminish the impairment, or</li> <li>• Prevent significant deterioration in an important area of life functioning, or</li> <li>• Except as provided in Section 1830.210, allow the child to progress developmentally as individually appropriate.</li> <li>• For a child who meets the criteria of Section 1830.210(1), meet the criteria of Section 1830.210(b) and (c).</li> </ul> </li> <li>• The condition would not be responsive to physical health care based treatment.</li> </ul>
<p><b>Title 9 CCR § 1830.210:</b> For MHP coverage for <b>outpatient specialty mental health services for eligible beneficiaries under 21 years of age</b>, the patient and/or service must meet the following:</p>	
<p>Has one of the following diagnoses in the DSM-IVE:</p> <ul style="list-style-type: none"> <li>• Pervasive Developmental Disorders, except Autistic Disorders</li> <li>• Disruptive Behavior and Attention Deficit Disorders</li> <li>• Feeding and Eating Disorders of Infancy and Early Childhood</li> <li>• Elimination Disorders</li> <li>• Other Disorders of Infancy, Childhood, or Adolescence</li> <li>• Schizophrenia and other Psychotic Disorders, except Psychotic Disorders due to a General Medical Condition</li> <li>• Mood Disorders, except Mood Disorders due to a General Medical Condition</li> </ul>	<p>The beneficiary has a condition that would not be responsive to physical health care based treatment, <b>and</b></p> <p>The services are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services with respect to the mental disorder<sup>40</sup></p>

<sup>40</sup> Other standards apply for eligibility for targeted case management.

<ul style="list-style-type: none"><li>• Anxiety Disorders, except Anxiety Disorders due to a General Medical Condition</li><li>• Somatoform Disorders</li><li>• Factitious Disorders</li><li>• Dissociative Disorders</li><li>• Paraphilias</li><li>• Gender Identity Disorder</li><li>• Eating Disorders</li><li>• Impulse Control Disorders Not Elsewhere Classified</li><li>• Adjustment Disorders</li><li>• Personality Disorders, excluding Antisocial Personality Disorder</li><li>• Medication-Induced Movement Disorders related to other included diagnoses</li></ul>	
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## Appendix B

### Identifying the Players and Governing Authorities

Medi-Cal Managed Care Plans: There are three main models of Medi-Cal managed care plans, including county operated health systems, geographic managed care plans and two-plan model/regional model plans. The county operated health systems serve beneficiaries in Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, Ventura and Yolo Counties. Geographic managed care serves beneficiaries in Sacramento and San Diego Counties. All other counties, with the exception of San Benito that has a unique Medi-Cal managed care program, through a two-plan, modified two-plan or regional model.

Non-COHS Medi-Cal managed care plans are subject to a myriad of rules: federal Medicaid laws, the 1115 waiver, state Medi-Cal laws, the contracts between the non-COHS Medi-Cal plans and the State and the Knox-Keene Act. The state has adopted laws governing non-COHS Medi-Cal managed care plans.

Unlike non-COHS Medi-Cal managed care plans, COHS Medi-Cal managed care plans are subject to few state laws and are exempt from certain federal requirements. They are also exempt from Knox-Keene licensure with respect to their Medi-Cal lines of business. However, they continue to be subject to the 1115 waiver and certain legal requirements are made applicable to them pursuant to their contracts with the State.

Cal MediConnect Plan: Cal MediConnect plans operate in seven counties (Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara) and administer the Medi-Cal and Medicare benefits for dual eligible beneficiaries enrolled in the Cal MediConnect program. Cal MediConnect plans are subject to the plans' three-way contracts with CMS and DHCS, the memorandum of understanding between DHCS and CMS and state and federal laws governing dual demonstration projects. In addition, non-COHS Cal MediConnect plans are subject to the Knox-Keene Act. In some areas, the Cal MediConnect plans apply Medicare Advantage rules when the patient is receiving services that would have otherwise been covered by Medicare if the patient was not enrolled in Cal MediConnect. In these situations, if the patient is receiving care that would have otherwise been covered by Medi-Cal, then the plans apply Medi-Cal rules.

County Mental Health Plan: County mental health plans operate as prepaid inpatient health plans under federal law. They are subject to the State's 1915(b) Medi-Cal Specialty Mental Health Services Waiver, their contracts with the State, federal laws governing prepaid inpatient health plans and applicable state law. They are not health care service plans subject to the Knox-Keene Act.

## Appendix C

### MMCD 00-01 Excerpt (Redlines from Revised Guidance from DHCS)

#### Emergency Services and Care

The assignment of financial responsibility to the Plan or the MHP for charges resulting from emergency services to determine whether a psychiatric emergency exists under the conditions provided in Title 9, CCR, Section 1820.225, ~~and the care and treatment necessary to relieve or eliminate the emergent condition~~ is generally determined by:

- The diagnosis assigned to the emergent condition;
- The type of professional performing the services; and
- Whether such services result in the admission of the Plan member for psychiatric inpatient hospital services at the same or a different facility.

It is suggested that the assignment of financial responsibility for emergency room facility charges and professional services be addressed as a component of the MOU.

#### Emergency Room Facility Charges and Professional Services

Financial responsibility for charges resulting from the emergency services and care of a Plan member whose condition meets the medical necessity criteria for coverage by the MHP is contractually assigned as follows:

- The Plan shall cover and pay for the facility charges resulting from the emergency services and care of a Plan member whose condition meets MHP medical necessity criteria when such services and care do not result in the admission of the member for psychiatric inpatient hospital services or when such services result in an admission of the member for psychiatric inpatient hospital services at a different facility.
- The MHP ~~shall cover and pay~~ is responsible for the facility charges resulting from the emergency services and care of a Plan member whose condition meets MHP medical necessity criteria when such services and care do result in the admission of the member for psychiatric inpatient hospital services at the same facility. The facility charge is not paid separately, but is included in the per diem rate for the inpatient stay.
- ~~The Plan shall cover and pay for the facility charges resulting from the emergency services and care of a Plan member whose condition meets MHP medical necessity criteria at a hospital that~~

~~does not provide psychiatric inpatient hospital services, when such services and care do result in the transfer and admission of the member to a hospital or psychiatric health facility that does provide psychiatric inpatient hospital services. The Plan is not responsible for the separately billable facility charges related to the professional services of a mental health specialist at the hospital of assessment. The MHP may pay this charge, depending on its arrangement with the hospital.~~

- The MHP is responsible for facility charges directly related to the professional services of a mental health specialist provided in the emergency room when these services do not result in an admission of the member for psychiatric inpatient hospital services at that facility or any other facility.
- ~~The Plan shall cover and pay for the medical professional services required for the emergency services and care of a member whose condition meets MHP medical necessity criteria when such services and care do not result in the admission of the member for psychiatric inpatient hospital services.~~
- The MHP shall cover and pay for the professional services of a mental health specialist ~~required for the emergency services and care of~~ provided in an emergency room to a Plan member whose condition meets MHP medical necessity criteria or when mental health specialist services are required to assess whether MHP medical necessity is met ~~when such services and care do result in the admission of the member for psychiatric inpatient hospital services.~~
- The Plan shall cover and pay for all professional services except the professional services of a mental health specialist, when required for the emergency services and care of a member whose condition meets MHP medical necessity criteria.

Payment responsibility for charges resulting from the emergency services and care of a Plan member with an excluded diagnosis or for a plan member whose condition does not meet MHP medical necessity criteria shall be assigned as follows:

- The plan shall cover and pay for the facility charges and the medical professional services required for the emergency services and care of a Plan member with an excluded diagnosis or a Plan member whose condition does not meet MHP medical necessity criteria and such services and care do not result in the admission of the member for psychiatric inpatient hospital services.
- Payment for the professional services of a mental health specialist required for the emergency services and care of a Plan member with an excluded diagnosis is the responsibility of the Medical FFS system.

**NOTE:** Effective January 1, 2000, SB 349 (Chapter 544, Statutes of 1999), redefines the definition of emergency services and care as it applies only to health care service plans where coverage for mental health is included as a benefit. SB 349 redefines the Health and Safety Code definition of emergency services and care to include an additional screening, examination, and evaluation to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric medical condition, within the capability of the facility. The provisions of SB 349 are a clarification of the definition of emergency services and care and a clarification of an existing responsibility and not the addition of a new responsibility. SB349 does not change the assigned responsibilities of the Plan and the MHP to pay for emergency services as described above.

Enclosure 3

**SAMPLE (continued)**

**MATRIX OF MANAGED CARE PLAN/ MENTAL HEALTH PLAN RESPONSIBILITIES**

Responsibility	Type of Service	Included Diagnosis and Meets MHP Impairment and Intervention Criteria	Excluded Diagnosis	Included Diagnosis But Does Not Meet MHP Impairment and Intervention Criteria
<b>Emergency Departments</b>	<b>Facility Charges</b>	MCP for initial triage and medical services  MHP for any facility charges related to a covered psychiatric service  <u>Note:</u> When a beneficiary is admitted to a psychiatric bed at the same facility, there is no separate payment for the ER by the MHP or the MCP	MCP	MCP
	<b>Psychiatric Professional Services</b>	MHP	EDS	No MHP, MCP, or EDS payment
	<b>Medical Professional Services</b>	MCP	MCP	MCP

## Appendix D

### Attachment 1 to APL 13-021: Mental Health Services Description Chart for Medi-Cal Managed Care Members

DIMENSION	Medi-Cal <sup>41</sup>	MHP <sup>42</sup> Outpatient	MHP Inpatient
ELIGIBILITY	<p style="text-align: center;"><b>Mild to Moderate Impairment in Functioning</b></p> <p>A member is covered by the MCP for services if he or she is diagnosed with a mental health disorder as defined by the current DSM<sup>43</sup> resulting in mild to moderate distress or impairment of mental, emotional, or behavioral functioning:</p> <ul style="list-style-type: none"> <li>• Primary care providers identify the need for a mental health screening and refer to a specialist within their network. Upon assessment, the mental health specialists can assess the mental health disorder and the level of impairment and refer members that meet medical necessity criteria to the MHP for a Specialty Mental Health Services (SMHS) assessment.</li> <li>• When a member's condition improves under SMHS and the mental health providers in the MCP and MHP coordinate care, the member may</li> </ul>	<p style="text-align: center;"><b>Significant Impairment in Functioning</b></p> <p>A member is eligible for services if he or she meets all of the following medical necessity criteria:</p> <ol style="list-style-type: none"> <li>1. Has an included mental health diagnosis;<sup>44</sup></li> <li>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, or a reasonable probability of not progressing developmentally as individually appropriate;</li> <li>3. The focus of the proposed treatment is to address the impairment(s) described in #2;</li> <li>4. The expectation that the proposed treatment will significantly diminish the impairment, prevent significant deterioration in an important area of life function, and</li> <li>5. The condition would not be responsive to physical</li> </ol>	<p style="text-align: center;"><b>Emergency and Inpatient</b></p> <p>A member is eligible for services if he or she meets the following medical necessity criteria:</p> <ol style="list-style-type: none"> <li>1. An included diagnosis;</li> <li>2. Cannot be safely treated at a lower level of care;</li> <li>3. Requires inpatient hospital services due to one of the following which is the result of an included mental disorder:               <ol style="list-style-type: none"> <li>a. Symptoms or behaviors which represent a current danger to self or others, or significant property destruction;</li> <li>b. Symptoms or behaviors which prevent the beneficiary from providing for, or utilizing, food, clothing, or shelter;</li> <li>c. Symptoms or behaviors which present a severe risk to the beneficiary's physical health;</li> </ol> </li> </ol>

<sup>41</sup> Medi-Cal Managed Care Plan.

<sup>42</sup> County Mental Health Plan Medi-Cal Specialty Mental Health Services.

<sup>43</sup> Current policy is based on DSM IV and will be updated to DSM 5 in the future.

<sup>44</sup> As specified in Title 9, CCR, Sections 1820.205 and 1830.205 for adults and 1830.210 for those under age 21.

DIMENSION	Medi-Cal <sup>41</sup>	MHP <sup>42</sup> Outpatient	MHP Inpatient
	<p>return to the MH provider in the MCP network.</p> <p><i>Note: Conditions that the current DSM identifies as relational problems are not covered, i.e. couples counseling or family counseling.</i></p>	<p>health care-based treatment.</p> <p><i>Note: For members under age 21 who meet criteria for EPSTD specialty mental health services, the criteria allow for a range of impairment levels<sup>45</sup> and include treatment that allows the child to progress developmentally as individually appropriate.</i></p>	<p>d. Symptoms or behaviors which represent a recent, significant deterioration in ability to function;</p> <p>e. Psychiatric evaluation or treatment which can only be performed in an acute psychiatric inpatient setting or through urgent or emergency intervention provided in the community or clinic; and</p> <p>f. Serious adverse reactions to medications, procedures or therapies requiring continued hospitalization.</p>
SERVICES	<p>Mental health services when provided by licensed mental health care professionals (as defined in the Medi-Cal provider bulletin) acting within the scope of their license:</p> <ul style="list-style-type: none"> <li>• Individual and group mental health evaluation and treatment (psychotherapy)</li> <li>• Psychological testing when clinically indicated to evaluate a mental health condition</li> <li>• Outpatient services for the purposes of monitoring medication therapy</li> <li>• Outpatient laboratory, medications, supplies, and supplements</li> <li>• Psychiatric consultation</li> </ul>	<p>Medi-Cal Specialty Mental Health Services:</p> <ul style="list-style-type: none"> <li>• Mental Health Services <ul style="list-style-type: none"> <li>o Assessment</li> <li>o Plan development</li> <li>o Therapy</li> <li>o Rehabilitation</li> <li>o Collateral</li> </ul> </li> <li>• Medication Support Services</li> <li>• Day Treatment Intensive</li> <li>• Day Rehabilitation</li> <li>• Crisis Residential</li> <li>• Adult Crisis Residential</li> <li>• Crisis Intervention</li> <li>• Crisis Stabilization</li> <li>• Targeted Case Management</li> </ul>	<ul style="list-style-type: none"> <li>• Acute psychiatric inpatient hospital services</li> <li>• Psychiatric Health Facility Services</li> <li>• Psychiatric Inpatient Hospital Professional Services if the beneficiary is in fee-for-service hospital</li> </ul>

<sup>45</sup> See footnote 44.

## Appendix E

### Federal and State Definitions of Emergency Medical Services Applicable to Emergency Psychiatric Medical Conditions

<b>Federal Definitions</b>		<b>California Definitions</b>	
<b>EMTALA Definition</b>	<b>Medicaid Definition</b>	<b>California Hospital Licensing Definition</b>	<b>Medi-Cal MHP Definition</b>
“Emergency medical condition”	“Emergency medical condition”	“Psychiatric emergency medical condition”	"Emergency psychiatric condition"
a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in	a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in	a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following --	a condition that meets the criteria in Section 1820.205 <sup>46</sup> when the beneficiary with the condition, due to a mental disorder --
(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;	(i) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child, or	(i) an immediate danger to himself or herself or to others, or	(i) is a current danger to self or others, or
(ii) serious impairment to bodily functions; or	(ii) serious impairment to bodily functions; or	(ii) immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder	(ii) immediately unable to provide for or utilize, food, shelter or clothing, and
(iii) Serious dysfunction of any bodily organ or part; or	(iii) serious dysfunction of any bodily organ or part		(iii) requires psychiatric inpatient hospital or psychiatric health facility services

<sup>46</sup> Title 9, CCR Section 1820.205 defines the term “medical necessity.” See Appendix A.

<b>Federal Definitions</b>		<b>California Definitions</b>	
<b>EMTALA Definition</b>	<b>Medicaid Definition</b>	<b>California Hospital Licensing Definition</b>	<b>Medi-Cal MHP Definition</b>
<p>with respect to a pregnant woman who is having contractions</p> <p>(i) that there is inadequate time to effect a safe transfer to another hospital before delivery; or</p> <p>(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.</p>			