QRTips

January 2015

Revised 9/2015

SB 785 Out-of-County Cases - Information

SB 785 rules applies when a client's Medi-Cal "belongs" to a county of origin OTHER THAN the County of Orange. When this is the case, we are required to seek out the county of origin's authorization in order to provide assessment and treatment services within our Mental Health Plan.

Who is covered?

- ✓ **Adopted clients** with an AAP MediCal aid code (03, 04, 4A, 06, 07)
- ✓ **Foster clients with a relative caregiver**, with a KinGAP aid code (4F, 4G, 4S, 4T, 4W)
- ✓ **Foster clients with a foster aid code** (4H, 4K, 4L, 40, 42, 43, 45, 46, 49, 5K, etc.)

Note: All clients require authorization from the county of origin. Clients with AAP or KinGap aid codes are treated as if they had Orange County Medi-Cal. For clients who do not have an AAP or KinGap aid code, the county of origin is responsible for arranging/providing the necessary mental health services. These clients can be seen by a HCA CYBH provider on a case-by-case basis (Please contact Nathan Lopez or Asmeret Hagos at 714-834-5015).

- In order to begin the assessment for a non-AAP or non-KinGap aid code child/youth an SAR must be sent to the county of origin for their approval. The assessment cannot begin until proper authorization is obtained from the county of origin. During assessment, you are NOT authorized to provide any other types of services and there is no provision for use of an Interim Care Plan (ICP) in order to do so.

- Once you have forwarded your completed and signed state standardized SB 785 Service Authorization Request (SAR), Client Assessment and Client Plan forms to the representative in the **client's County of origin**, you may begin billing for treatment services as of that date.

  Note: As long as you record in the chart that the documents were in fact sent to the county-of-origin and that they were received, you are authorized to bill Medi-Cal from that point forward.

- CYBH clinician specifies the number of minutes, start and end dates (for example, 720 minutes over the next 60 days). Some counties will place a limit on the duration and frequency of services and will make changes to the SAR accordingly. During the specified assessment period, **you can only assess the client**, but nothing further than what was written on the authorization request. You are **not allowed** to bill for assessment after the authorization expires unless the out of county representative gives an extension.

- On the day after the end date, **if you are without a completed assessment and treatment plan or extension for assessment**, you may only bill using non-compliant chart codes.

  It is recommended that if you do not hear from the county of origin within a reasonable time period, **please follow up with the county of origin representative and document** this in the chart.

- If, however, after the assessment, you determine that **there is no medical necessity**, or **if the county of origin denies treatment services**, it is the **county of origin's responsibility** to give the

consumer the NOA-A. You would need to notify the county of origin representative that the child did not meet medical necessity, so that they could follow through with the NOA-A.

In order to alert treatment team members and external auditors to the fact that a given case is an active SB-785 case, we strongly recommend that you **complete an MTP update** (this does not apply to county-operated clinics with EHR) that will communicate this information clearly in the consumer's chart.

Only the following sections from the usual MTP pages would be filled out differently.

- The **Update Page** section labels the type of MTP and references the out of county paperwork authorization.
- The **Medi-Cal month/year of intake references** out of county timelines.
- The **types of services list** what the out of county services are with their authorization dates.

For County EHR programs, we are **currently using the Conversion Care Plan** which is the only tool in the EHR that allows us to manually enter an end date for the Care Plan. This applies to SB-785 cases since county of origin representatives **often authorize up to 6 months instead of a full year**, which is the default in our EHR. Presently, **only Service Chiefs can do the Conversion Care Plan**, so they would have to put the information in the EHR once you receive the out of county authorization.

There have been instances where outside counties authorize a year of mental health services. In these situations the regular EHR care plan can be used. The care plan can reference the SB 785 documentation which can be scanned into the EHR.

- Please note that this process may change as the EHR is updated. Check with your service chief or your email from the EHR blog for any upcoming changes.