HEALTH AND HUMAN SERVICES AGENCY
MENDOCINO COUNTY MENTALHEALTH BRANCH

POLICY AND PROCEDURE

SUBJECT:	Point of Authorization Policy and Procedure
APPLICABLE PROGRAM(S):	Mendocino County Mental Health Managed Care Plan: Outpatient and Inpatient, Excluding DSS Katie A./WRAP
	Tom Pinizzotto, Mental Health Director
Signature:	Tom Pinizzotto JR

REVISED: 07/13, 11/13, 3/14

POLICY:

Mendocino County, Medi-Cal Managed Care Mental Health Plan (MHP) shall ensure compliance with CCR, Title 9, Chapter 11, sections 1810-1840; and CFR, Title 42, section 438. These statutes cover all matters concerning authorization of inpatient and outpatient services, and Treatment Authorization Requests (TARs). For Day Treatment Rehabilitation and Intensive, they shall comply with DHM Letter No. 03-03 and DMH info Notice 02-06, enclosures, Pages 1-5.

Mendocino County Mental Health Plan Providers will abide by the following Access and Point of Authorization process. Mendocino County MHP will maintain a POA office that will provide oversight of the following:

ACCESS STRUCTURE:

Mendocino County Mental Health Services can be accessed by:

1. A statewide Emergency Crisis/Access, 24 hour a day, 7 days a week (24/7) toll free number (800) 555-5906 for emergency and urgent care.
   (Urgent Conditions are defined as a situation experienced by a client that without intervention is highly likely to result in an immediate emergency psychiatric condition.)

2. Non-emergency Help Lines (707) 472-0126 in Ukiah and (707) 964-4747 in Fort Bragg

3. Mental Health Service Centers:

Adult Services:
Access Center: 1050 N. State St., Ukiah, CA
Access Center: 474 S. Franklin St., Fort Bragg, CA

Children's Services:
Access Center: 723 S. Dora St., Ukiah, CA
Redwood Children's Services (RCS): 350 Gobbi St., Ukiah, CA
RCS Willits: 99 S. Humboldt St., Willits, CA
RCS Fort Bragg: 32670 Highway 20, Unit #2, Fort Bragg, CA
Tapestry Family Services: 290 E. Gobbi St., Ukiah, CA
Mendocino County Youth Project: 776 F. State St., Ste.107, Ukiah, CA

4. OMG and RQMC will submit a monthly Access/Crisis/Phone Log to MC-POA by the 10th of each subsequent month.

HOSPITAL SERVICES UTILIZATION FOR MENDOCINO COUNTY POINT OF AUTHORIZATION (MC-POA):

1. "Crisis Services" (emergency and urgent care) do not require pre-authorization.

2. Crisis Services, placement of crisis clients and acute/emergency hospital stays will be managed by Ortner Management Group (OMG) and Redwood Quality Management Company (RQMC).

3. OMG and RQMC will notify MC-POA within seven (7) calendar days of their knowledge of any crisis evaluation and hospitalization via the Crisis Evaluation/Hospitalization Authorization Form (MC-POA fax 707-463-6868). MC-POA will provide verification of notification of crisis evaluation and/or hospitalization and an authorization number for post crisis specialty mental health services and case management within fourteen (14) calendar days.
4. OMG and RQMC will manage and review charts daily and authorize as appropriate.
5. OMG and RQMC will seek ongoing, provisional authorization by MC-POA within 72 hours of initial hospitalization
6. TARs, Hospital Charts and Hospital Chart Audit Sheets will be sent to the MC-POA Office for 100% review and signature prior to payment.
7. OMG and RQMC in collaboration with MC-POA Office will approve or deny all TARs within fourteen (14) calendar days (9 days for OMG/RQMC and five (5) days for MC-POA) of the receipt of the TAR and in accordance with all Title 9 regulations (unless a qualified exception occurs).
8. All TARs are approved or denied by licensed mental health or waivered/registered professionals, employed by the MHP.
9. OMG and RQMC will submit a monthly Hospitalization log to MC-POA by the 10th of each subsequent month.

INPATIENT HOSPITAL PAYMENT / ADVERSE DECISIONS

"Adverse Decision" means denial or termination of payment authorized by the MHP's Point of Authorization and/or its Contracted Providers OMG and RQMC Point of Authorization.

Inpatient Authorization

A hospital shall submit the request for MHP payment authorization for psychiatric inpatient hospital services to the appropriate MHP contracted provider (RQMC & OMG) no later than 99 calendar days of continuous service to a beneficiary if the hospital stay exceeds that period of time OR within 14 calendar days after discharge.

A. The written request for payment shall be in the form of a Treatment Authorization Request (TAR) for Fee-for-Service/Medi-Cal hospitals or as specified by the MHP for Short Doyle/Medi-Cal Hospitals.

B. The Point of Authorization staff that approve or deny payment shall be licensed mental health or waivered/registered professionals.

C. Approval or disapproval of payment must be in writing:

   1. On the same TAR on which the Fee-For-Service/Medi-Cal Hospital requested payment authorization.

   2. And, in an MHP payment authorization log maintained by the MHP or its contracted provider for Short-Doyle /Medi-Cal hospitals.

   3. The POA shall document that all adverse decisions regarding hospital requests for MHP payment authorization is based on medical necessity criteria or the criteria for emergency admission that were reviewed, documented and approved:

      a. **By a physician**, or
      b. At the discretion of the MHP, by a psychologist for patients admitted by a psychologist and who received services under the psychologist's scope of practice.

D. A request for payment authorization may be denied by the POA if the request is not submitted in accordance or within timelines as identified above or does not meet medical necessity reimbursement criteria in Title 9, 1820-205 or emergency psychiatric condition criteria in Title 9, 1820.225(b) on an emergency admission or if the hospital has failed to meet any other mandatory requirements of the contract negotiated between the hospital the MHP or its Contracted Provider(s).

E. The POA shall approve or deny the request for payment authorization within fourteen (14) calendar days of the receipt of the request and, for a request from a Fee-for-Service Medi-Cal Hospital, shall submit the TAR to the fiscal intermediary within 14 calendar days of approval or denial.

F. Requests for continued stay shall be approved if written documentation has been provided to the POA indicating that the beneficiary met the medical necessity reimbursement criteria for acute psychiatric inpatient hospital services for each day of services.

G. Requests for administrative day services must meet the following conditions:

   1. During the hospital stay a beneficiary previously met medical necessity criteria for

reimbursement of acute psychiatric inpatient hospital services.

2. There is no appropriate, non-acute residential treatment facility in a reasonable geographic area and a hospital documents contacts with a minimum of five appropriate non-acute residential treatment facilities per week subject to the following:

   a. POA staff may waive the requirement of five contacts per week if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options. In no case should there be less than one contact per week.
   b. The lack of placement options and the contacts made must be documented.

H. In the event of an adverse decision a Notice of Action (NOA) will be issued by MC-POA. See NOA policy.

OUTPATIENT SERVICE UTILIZATION FOR MENDOCINO COUNTY POINT OF AUTHORIZATION (MC-POA):

Pre-Authorization Procedure:

1. Initial authorization for up to 240 minutes (4 hrs) of assessment and 120 minutes (2hrs) of plan development for sixty (60) calendar days (from the date of service request) will be automatically authorized at the access locations. The purpose is to establish Medical Necessity.
   a. When medical necessity is met the MHP provider will include utilized 4hrs of assessment and 2 hrs of plan development in the first TAR.
   b. When medical necessity is not met Contract MHP provider will issue a NOA and send a copy to MC-POA. The Contract MHP will also retain a copy for record keeping purposes.

2. Mendocino County Children's Center (MC3) services do not require pre-authorization for the first five (5) days; 2,880 minutes (48 hrs) of services will be provided (assessment, individual rehabilitation, individual therapy, family therapy, and case management). For the following 25 days, the services will be individualized to meet the client's needs for up to 7,920 min (132 hrs). These services may consist of assessment, client plan development, individual rehabilitation, group rehabilitation, family therapy, collateral and case management services.
3. Katie A. services do not require pre-authorization for the first five (5) days; 2,880 minutes (48hrs) of services will be provided (Biopsychosocial Assessment, Client Plan, Intensive Care Coordination, and Intensive Home Based Services).
4. Crisis services do not require pre-authorization. Crisis services are considered an emergency service. Crisis services can be billed up to eight (8) hours in every 24 hours.

Authorization Procedure:

1. All other outpatient services (including Day Treatment Services and EPSDT) must submit a completed TAR, CANS/ANSA, Biopsychosocial Assessment and Client Plan to OMG/RQMC POA for medical necessity review and authorization. OMG/RQMC will submit the TARs, CANS/ANSA and Medi-Cal print out to MC-POA for oversight and final authorization. MC-POA will issue an authorization number for every authorized TAR for purposes of reimbursement. Services will be authorized for up to 6 months.

2. All programs will use a TAR Form, approved by the MC-POA. All TARS will be processed within fourteen (14) calendar days from the date of receipt ((7) seven calendar days for OMG/RQMC and (7) seven calendar days for MC-POA). OMG/RQMC will date stamp the receipt of the TAR and MC-POA will stamp the date of the authorization.

3. Forms that are incomplete will be sent back with an explanation. These TARs will be processed when all forms are fully completed and returned to MC-POA.

4. All providers will use the Crisis Intervention/Hospitalization Authorization form for authorization of post crisis services. Post crisis service is approved for 2,400 minutes (40 hrs) of post crisis specialty mental health services and case management within sixty (60) days from the date of the initial crisis assessment. (For Mendocino County Medi-Cal Beneficiaries Only)

5. All providers will conduct biopsychosocial assessments at least annually. Client plans and CANS/ANSA will be re-done every 6 months. Up to 240 minutes will be authorized for initial assessment and 120 minutes will be authorized for re-assessment. Up to 120 minutes will be authorized for client plan development.

Re-Authorization Procedure:

1. Required re-authorization documents include a new TAR, Client Plan and CANS/ANSA.
2. Re-authorization documents are due a minimum of seven (7) calendar days and no more than thirty (30) days prior to the expiration of the current authorization.
   For example:
   a. Prior authorization expires on 9/30/13.
   b. TAR and new Treatment Plan would be due by 9/23/13.
   c. The new authorization period would be from 10/1/13 through 3/31/14.
3. Authorization will be provided to the MHP contract providers in no more than 14 calendar days. (42 CFR 438.210)

Authorization Audit

MC-POA will audit OMG and RQM every three months with regards to TAR requirements and Medical Necessity. MC-POA will request 15 full TAR packets every three months to audit. The audit period will include the prior three months and will be randomly chosen. The packet will include TAR, BPSA (assessment), Client Plan, ANSA/CANS, and Katie A Subclass Assessment (if applicable).

Adverse Decisions: Outpatient Specialty Mental Health Services (SMHS)

The organization that is denying SMHS will follow the following procedure:

1. Notification by the MHP to the Provider will be made via a denial letter.

2. Notification to the beneficiary must be made in writing via the appropriate Notice of Action. (A copy of the NOA will also be submitted to MC-POA)

3. Appeals of Authorization Denials and Payment Denials may be made to the MC-POA with fourteen (14) days of the date of the notice.

4. MC-POA will be notified within 48 hours of any appeals.

Notification is also sent to the beneficiary of the denial in writing via the appropriate NOA no later than the third working day after the action. See NOA policy.

Expedited authorization decision:

Mendocino County, Medi-Cal Managed Care Mental Health Plan (MHP) shall ensure compliance with CFR, Title 42, section 438.210 (d) (1).(2) for Expedited Authorization Decisions.

Contract MHP Providers or MC-POA must provide expedited authorization decision and notice as expeditiously as the beneficiary's health condition requires and within three (3) working days following receipt of the request for service or, when applicable, within fourteen (14) calendar days of extension. Mendocino County Children's Center (MC3), Service Authorization Requests (SARs) and Katie A. TARS require expedited decisions and must be authorized within three (3) working days.

Attachments:

1 Medical Necessity for Specialty Mental Health Services that are the Responsibility of the Mental Health Plan (Title 9 § 1820.220)
2 Treatment Authorization Request (TAR) for outpatient services and Instructions
3 HHSA- Behavioral Health & Recovery Services Outpatient Chart Audit Tool
4 Crisis Intervention/ Hospitalization Authorization Form
5 Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient Hospital Services
6 Acute Inpatient Hospitalization Audit Guidelines
7 Chart Review Worksheet-Short Doyle/Medi-Cal Hospital Services-Day of Admission and Plan of Care
8. Monthly Access/Crisis/Phone Log
9. Monthly Hospitalization Log

STATE DEPARTMENT OF MENTAL HEALTH MEDI-CAL MANAGED CARE

MEDICAL NECESSITY FOR SPECIALTY MENTAL HEALTH SERVICES

that are the Responsibility of the Mental Health Plan

Must have all, A, B, and C:

A. Diagnoses

Must have one of the following DSM IV diagnoses, which will be the focus of the intervention being provided:

Included Diagnoses:

- Pervasive Developmental Disorders, except Autistic Disorder which is excluded.
- Attention Deficit and Disruptive Behavior Disorders
- Feeding & Eating Disorders of Infancy or Early Childhood
- Elimination Disorders
- Other Disorders of Infancy, Childhood, or Adolescence
- Schizophrenia & Other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Paraphilias
- Gender Identity Disorders
- Eating Disorders
- Impulse-Control Disorders Not Elsewhere Classified
- Adjustment Disorders
- Personality Disorders, excluding Antisocial Personality Disorder
- Medication-Induced Movement Disorders

Excluded Diagnoses:

- Mental Retardation
- Learning Disorders
- Motor Skills Disorder
- Communication Disorders
- Autistic Disorder (Other Pervasive Developmental Disorders are included.)
- Tic Disorders
- Delirium, Dementia and Amnestic and other Cognitive Disorders
- Mental Disorders due to a General Medical Condition
- Substance-Related Disorders
- Sexual Dysfunctions
- Sleep Disorders
- Antisocial Personality Disorder
- Other conditions, including V-codes, that may be a focus of Clinical Attention. (Except medication induced movement disorders which are included.)

A beneficiary may receive services for an included diagnosis when an excluded diagnosis is also present.

B. Impairment Criteria

Must have one of the following as a result of the mental disorder(s) identified in the diagnostic ("A") criteria: Must have one, 1, 2, or 3:

1. A significant impairment in an important area of life functioning, or
2. A probability of significant deterioration in an important area of life functioning, or
3. Children also qualify if there is a probability the child will not progress developmentally as individually appropriate. Children covered under EPSDT qualify if they have a mental disorder which can be corrected or ameliorated (current DHS EPSDT regulations also apply).

C. Intervention Related Criteria

Must have all, 1, 2, and 3 below:

1. The focus of proposed intervention is to address the condition identified in impairment criteria "B" above, and
2. It is expected the beneficiary will benefit from the proposed intervention by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning, and/or for children it is probable the child will progress developmentally as individually appropriate (or if covered by EPSDT can be corrected or ameliorated), and
3. The condition would not be responsive to physical healthcare based treatment.

EPSDT beneficiaries with an included diagnosis and a substance related disorder may receive specialty mental health services directed at the substance use component. The intervention must be consistent with, and necessary to the attainment of, the specialty MH treatment goals.

MENDOCINO COUNTY HHSA - BEHAVIORAL HEALTH & RECOVERY SERVICES BRANCH

(TAR)Treatment Authorization Request

For specialty mental health services

POINT OF AUTHORIZATION

1120 South Dora Street, Ukiah, CA 95482

Ph:(707)472-2360, Fax:(707)463-6868

Authorization #		**Total Minutes**	**Expedited Authorization Request:** ☐	**CANS/ANSA:**
Authorization Period:			**Funding Source:**	**Date TAR Received:**

Confidential

Directions: Authorization request must be received at least 7 calendar (and no more than 30) days prior to the expiration of current authorization

All information below must be filled out completely.

CLIENT INFORMATION:			**THIS TREATMENT AUTHORIZATION START DATE:**	
NAME:				
MEDI-CAL/ SSN #		M ☐ F ☐	DOB:	Age:

CLINICIAN'S NAME:			
Program name:		Phone:	Fax:
Mailing address:		ITFC: Yes ☐ No ☐	Adoption: Yes ☐ No ☐

REQUESTED TREATMENT SERVICES IN MINUTES (TO BE FILLED OUT BY SERVICE PROVIDER)			**TOTAL APPROVED MINUTES FILLED OUT BY MC- POINT OF AUTHORIZATION ONLY**					
Day Treatment Intensive (Half or Full day)		**Total Approved**	Individual Rehabilitative (minutes per month)		**Total Approved**	Family Therapy (minutes per month)		**Total Approved**
Day Treatment Rehabilitative sessions (Half or full day)		**Total Approved**	Group Rehabilitative (minutes per month)		**Total Approved**	Collateral (minutes per month)		**Total Approved**
Assessment (up to 240 minutes for initial assessment; up to 120 min for re-assessment)		**Total Approved**	Individual Therapy (minutes per month)		**Total Approved**	Case Management (minutes per month)		**Total Approved**
Client Planning (up to 120 min per request)		**Total Approved**	Group Therapy (minutes per month)		**Total Approved**	Medication Management (minutes per month)		**Total Approved**
Intensive Care Coordination - ICC (minutes per month)		**Total Approved**	Intensive Home Based Services – IHBS (minutes per month)		**Total Approved**			

MEDICAL NECESSITY	**Use DSM-IV (TR) Codes**		**Date the assessment was complete/sighed:**
DSM-IV Primary diagnosis		Secondary	
As a result of a mental disorder must have at least one:	☐ 1. A significant impairment in an important area of life functioning. ☐ 2. A probability of significant deterioration in an important area of life functioning. ☐ 3. A probability that the child will not progress developmentally as individually appropriate. ☐ 4. For full-scope MC beneficiaries under the age of 21 years, a condition as a result of the mental disorder that SMHS can correct or ameliorate.		
Must meet each of the intervention criteria:	☐ 1. The focus of the proposed intervention is to address the condition identified above, or for full-scope MC beneficiaries under the age of 21 years, a condition as a result of the mental disorder that SMHS can correct or ameliorate. ☐ 2. The proposed intervention will do at least one of the following: ☐ A. Significantly diminish the impairment. ☐ B. Prevent Significant deterioration in an important area of life functioning. ☐ C. Allow the child to progress developmentally as individually appropriate. ☐ D. For full-scope MC beneficiaries under the age of 21 years, correct or ameliorate the condition.		

TREATMENT INTENDED TO:	☐ Remedy condition	☐ Stabilize condition	☐ Assist the child to develop as individually appropriate
OTHER HEALTH CARE PROFESSIONALS INVOLVED IN CLIENTS TREATMENT:	RCRC ☐	FQHC ☐	Katie A./ DSS ☐ VA ☐ Other ☐
REFERRAL TO COMMUNITY RESOURCES-SELF HELP: Yes ☐ No ☐		**Resource Type(s):**	

Clinician's Signature:		Date:	
OMG/RQM Signature:		Date:	
MC-POA Signature:		Date:	

Treatment Authorization Request (TAR) Instructions

TARs must be received at least 7 calendar days (and no more than 30) days prior to the expiration of the current authorization.

For County Use Only:
The following areas are to be filled out by MC-POA:
"Authorization #", "Authorization Period", "Total Minutes", "CANS/ANSA", "Date TAR received". These areas will be completed and signed by MC-POA and will be mailed/faxed back to the provider.

Client Information (to be filled out by providers)
Check on top of the form when requesting an "Expedited Authorization"
Please use the client's Medi-cal name. (No alias' please), Gender, DOB, Age
A Social Security or Medi-cal number is required to process a TAR. Please include one or the other on your Treatment Authorization Request.
"This Treatment Authorization Start Date" is the date that you want the current Authorization to start (it can't be prior to client plan development).

Clinician Information (to be filled out by providers)
The Clinician's name is the licensed or waived provider who will sign the form. If you are an Organizational Provider, please fill out the program name.
If applicable, please indicate if the consumer is in ITFC or Adopted.

Requested Treatment Services:
Please fill in the services that you are requesting in minutes per month. (e.g. Group rehabilitation 240 min. per month)
Please do not fill out the box that says "***Total Approved"***, the Point of Authorization will complete this section. The total approved services are calculated by multiplying the number of months for that TAR by the number of requested services (in minutes).
(Please make sure the services that are requested are on the Client Plan)

Per Point Of Authorization Policy and Procedure, up to 240 minutes will be authorized for initial assessment and 120 minutes will be authorized for re-assessment. Up to 120 minutes will be authorized for client plan development.

Medical Necessity (To be filled out by providers)
Please fill in the date the biopsychosocial assessment was completed/signed
DSM diagnosis – Primary and Secondary
As a result of a mental disorder must have at least one (check that applies):
1. A significant impairment in an important area of life functioning.
2. A probability of significant deterioration in an important area of life functioning.
3. A probability that the child will not progress developmentally as individually appropriate.

4. For full-scope MC beneficiaries under the age of 21 years, a condition as a result of the mental disorder that SMHS can correct or ameliorate.

Must meet each of the intervention criteria (check that applies):
1. The focus of the proposed intervention is to address the condition identified above, or for full-scope MC beneficiaries under the age of 21 years, a condition as a result of the mental disorder that SMHS can correct or ameliorate.
2. The proposed intervention will do at least one of the following:
A. Significantly diminish the impairment.
B. Prevent Significant deterioration in an important area of life functioning.
C. Allow the child to progress developmentally as individually appropriate.
D. For full-scope MC beneficiaries under the age of 21 years, correct or ameliorate the condition

Treatment Intended to:
There can be more than one selection, i.e., treatment can stabilize and assist child to develop as individually appropriate.

Other Health Care Professionals Involved in Client's Treatment:
Check if applies. The standard of Care is to collaborate with the providers involved in the case.

Referral to Community Resources/Self Help:
This area should be marked "yes" if a client is being referred to a community resources and type of resources.

Signatures:
Please sign your name with the title after it and date.

Attachments:
Each TAR must have a completed Client Plan, Biopsychosocial assessment, CANS/ANSA and Medi-Cal Print out attached. If applicable, Katie A subclass assessment should also be attached.

HHSA- Behavioral Health & Recovery Services
Outpatient Chart Audit Tool

Client Name/Chart # _____ Staff Responsible for Chart _____ Agency/ Audit period _____

Yes	No	N/A	Integrity of the Chart
☐	☐	☐	1. All documents are legible
☐	☐	☐	2. The chart is organized in chronological order with all chart divider tabs in place
☐	☐	☐	4. Client name and chart number on each page (clinical record)
☐	☐	☐	5. Face Sheet info, esp. emergency contact info prominent (for every opening)

Yes	No	N/A	Forms
☐	☐	☐	6. Consent to treat signed annually
☐	☐	☐	7. HIPAA & informing material signature page signed annually
☐	☐	☐	8. Release of information signed annually (when applicable)
☐	☐	☐	9. Periodic Updates completed annually
☐	☐	☐	10. UMDAPs are fully completed and signed annually
☐	☐	☐	11. Informed Consent for Medication (s) (when applicable) signed by the beneficiary

Yes	No	N/A	Medical Necessity
☐	☐	☐	12. A 5-axis diagnosis from current DSM & primary diagnosis is included
☐	☐	☐	13. Is the beneficiary's diagnosis included in the list of diagnoses?
☐	☐	☐	14. Documents and/or assessment support medical necessity criteria
			15. Impairment criteria: must have one as a result of dx.
☐	☐	☐	a. A significant impairment in an important area of life functioning
☐	☐	☐	b. A probability of significant deterioration in an important area of life functioning
☐	☐	☐	c. A probability that the child will not progress developmentally as individually appropriate
☐	☐	☐	d. For full scope MC for beneficiaries under 21, a condition as a result of mental disorder that SMHS can correct or ameliorate.

Yes	No	N/A	
			16. Intervention Criteria: must have (a) and (b), or (c), or (d), or (e)
☐	☐	☐	a. Focus of the intervention is to address the condition identified above and
☐	☐	☐	b. Significantly diminish the impairment and/or

☐☐☐ c. Prevent significant deterioration in an important area of life functioning and/or

☐☐☐ d. Allow the child to progress developmentally as individually appropriate or

☐☐☐ e. For full scope MC for beneficiaries under 21, correct or ameliorate the condition

Yes No N/A **Biopsychosocial Assessment (BPSA)**

☐☐☐ 17. Initial BPSA is completed within 60 days from the initial request for services

☐☐☐ 18. Annual re-assessment completed within 30 days prior to the expiration of the previous assessment

☐☐☐ 19. If it's not possible to determine medical necessity within 60 days, the need for more time must be documented in PN and deadline extended to 90 days via Extension request

☐☐☐ 20. CANS/ANSA is completed at least annually

☐☐☐ 21. Returning clients: if within 6 month of an initial assessment then the assessment can be adopted and it can be updated with new information and signature; if after 6 months of an initial assessment then the assessment must be re-done.

22. BPSA includes the following:

☐☐☐ a. Presenting problem (chief complains, history of the problem, current level of functioning, relevant family history)

☐☐☐ b .Relevant conditions and psychosocial factors affecting physical and mental health (living Situation, daily activities, social, cultural, history of trauma)

☐☐☐ c. Mental health history (previous treatment, providers, modality and response)

☐☐☐ d. Medical history (relevant physical health conditions; for children prenatal and perinatal events and developmental history)

☐☐☐ e. Medications (past or current medications, duration, allergies or adverse reaction to meds)

☐☐☐ f. Substance exposure/substance use (past and present use)

☐☐☐ g. Clients strengths (in achieving client plan goals)

☐☐☐ h. Cultural components and primary language

☐☐☐ i. Risks (including past or current trauma)

☐☐☐ j. A mental status examination

☐☐☐ k. A complete 5 axis diagnosis from current DSM or current ICD code

☐☐☐ l. Additional clarifying formulation (as needed)

☐☐☐ 23. BPSA is signed and dated by a licensed/waived clinician

24. Medication consent: documentation that includes but not limited to:

☐☐☐ a. the reason for taking such medications

☐☐☐ b. reasonable alternative treatment available, if any

☐ ☐ ☐ c. the type range of frequency and amount, methods and duration, probable side effects, possible additional side effects which may occur if taking beyond 3 months

☐ ☐ ☐ d. consent given may be withdrawn at any time by the beneficiary.

Yes No N/A **Client Plan**

☐ ☐ ☐ 25. Initial Client Plan is completed within 60 days from the initial request for services

☐ ☐ ☐ 26. Client Plan is updated at least annually or when there are significant changes in the beneficiary's condition

☐ ☐ ☐ 27. Client Plan covers all progress notes

☐ ☐ ☐ 28. Plan is signed and dated by a licensed/waived clinician

☐ ☐ ☐ 29. Plan is signed and dated by client (12 y.o. and older)

☐ ☐ ☐ 30. Plan is signed/dated by client or legal representative; if not progress note needs to explain why and show attempts

☐ ☐ ☐ 31. Client Plan has the following elements

☐ ☐ ☐ a. Goals/Objectives are observable and/or quantifiable related to client's needs and functional impairments

☐ ☐ ☐ b. The proposed type of intervention/modality including a detailed description of the intervention

☐ ☐ ☐ c. The proposed frequency and duration of intervention(s)

☐ ☐ ☐ d. Interventions that focus and address the identified functional impairments as a result of mental disorder

☐ ☐ ☐ e. Interventions which are consistent with client plan goals/objectives

☐ ☐ ☐ f. Be consistent with the qualifying diagnosis

☐ ☐ ☐ 32. Plan indicates client was offered copy of Plan or client may obtain copy on request

Yes No N/A **Progress Notes**

☐ ☐ ☐ 33. There is a progress note for every service contact

☐ ☐ ☐ a. they describe how services are provided

☐ ☐ ☐ b. reduced impairment, restored functioning, or prevent significant deterioration outlined in Clt.P

☐ ☐ ☐ 34. Progress notes document the following:

☐ ☐ ☐ a. Timely documentation including documentation of medical necessity

☐ ☐ ☐ b. Documentation of beneficiary encounters, including relevant clinical decisions, alternative approaches for future interventions

☐ ☐ ☐ c. Interventions applied, location and beneficiary's response to the interventions

☐☐☐ d. The date the services were provided

☐☐☐ e. Documentation of referrals to community/agencies (when appropriate)
☐☐☐ f. Documentation of follow-up care/discharge summary (as appropriate)

☐☐☐ g. The amount of taken to provide services

☐☐☐ h. The signature of the person providing the services, professional degree, licensure or job title and ID (if applicable)

☐☐☐ i. The date the service was documented in the medical records

☐☐☐ j. The notes are entered in the clinical records within 14 calendar days of each service provided

☐☐☐ k. Late Entries: Note needs to identify itself as a late entry for the date of service

35. Timeliness/frequency as follows:
Every service contact for:
☐☐☐ a. Mental Health Services
☐☐☐ b. Medication Support Services
☐☐☐ c. Crisis Intervention
☐☐☐ d. Targeted case management

Daily for:
☐☐☐ e. Crisis residential
☐☐☐ f. Crisis stabilization (one per 23 hrs period)
☐☐☐ g. Day treatment intensive

Weekly for:
☐☐☐ h. Day treatment intensive (clinical summary)
☐☐☐ i. Day rehabilitation
☐☐☐ j. Adult residential

36. Group services
☐☐☐ a. Summary of the group's behavioral health goals/purpose
☐☐☐ b. Primary focus on the client's group interaction and involvement as relevant to their Clt. P.
☐☐☐ c. Notes include # of clients serviced and total service time

☐☐☐ 37. All progress notes are in DAP format

☐☐☐ 38. Only billable services provided during Jail/Juvenile Hall incarceration when a Court Order in the Chart and indicates adjudication awaiting placement.

☐☐☐ 39. No billable services were provided during hospitalization (except discharge planning T1016 (The date of admission <u>is</u> billable, Day of discharge <u>is not</u> billable <u>until after time of discharge</u>)

☐☐☐ 40. Services provided was NOT clerical, payee related or voicemail

☐☐☐ 41. The most recent note was written w/in the past 6 mos (if past 6 then closing summary in the chart)

☐☐☐ 42. Every note should state the language the service was provided (who interpreted- if applicable)

43. Crisis Services:
☐☐☐ a. CIC is fully completed
☐☐☐ b. A Progress note is written for every crisis service
☐☐☐ c. No more than 8 hrs billed within 24 hrs

☐☐☐ d. TBS services offered and receipt obtained

Yes No N/A TBS (if applicable)

☐☐☐ 44. Does the plan for TBS document the following (a-e):

☐☐☐ a. Specific target behaviors or symptoms that are jeopardizing the current place of residence or presenting a barrier to transitions

☐☐☐ b. Specific interventions to resolve behaviors or symptoms, such as anger management techniques?

☐☐☐ c. Specific outcome measures that can be used to demonstrate that the frequency of targeted behaviors has declined and has been replaced by adaptive behaviors?

☐☐☐ d. A transition plan from the inception of TBS to decrease or discontinue TBS when these services are no longer needed or when the need to continue TBS appears to have reached a plateau in benefit effectiveness?

☐☐☐ e. The manner for assisting parents/caregivers with skills and strategies to provide continuity of care when the service is discontinued?

☐☐☐ 45. TBS is listed on the Master Client Plan.

☐☐☐ 46. TBS completed, signed and dated by licensed/waivered clinician

☐☐☐ 47. There are TBS Monthly Reviews and Transition Plans forms present for each month of service

Yes No N/A Family Strengths/Katie A. (if applicable)

☐☐☐ 48. Katie A. mini assessment is completed and signed by licensed/waived clinician

☐☐☐ 49. Documentation of Katie A subclass criteria being met (every 90 days)

☐☐☐ 50. IHBS and ICC services are listed on the Client Plan

☐☐☐ 51. FS Addendum, completed and signed by a licensed/waived clinician (attached to Clt. Plan)

☐☐☐ 52. There is documentation of clinical oversight of Rehab Specialist interventions

☐☐☐ 53. Collaboration between MH, Contract Providers and CWS is documented in Clt Plan and PN

Review completed by:_____ Date:_____

Signature of Supervisor: _____ Date:_____

Signature of MC QA staff:_____ Date:_____

Mendocino County
Behavioral Health and Recovery Services

CRISIS INTERVENTION / HOSPITALIZATION AUTHORIZATION

OMG and RQM will notify MC-POA within 7 calendar days of their knowledge of a Crisis Intervention/Evaluation and Hospitalization conducted with a Mendocino Medi-Cal beneficiary.

MC-POA fax 707-463-6868.

Client Name: _____

Gender: _____

DOB: _____

Medi-Cal Number: _____

Date of assessment: _____

Place of assessment: _____

Agency: _____

Authorization # (by MC-POA) _____

MC-POA Signature/Date _____

This Authorization approves 40 hours of post Crisis Specialty Mental Health Services and Case Management within 60 days from the date of the initial crisis assessment. (For Mendocino County Medi-Cal Beneficiaries Only)

Prior approval for crisis services is not required. Crisis services are pre-approved for up to 8 hours in every 24 hours.

For hospitalization authorization:

Date of admission: _____ Place of admission: _____

Authorization #: _____ MC-POA signature/date: _____

Attach UMDAP and Periodic Update to this form

➡§ 1820.205. Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient Hospital Services.

(a) For Medi-Cal reimbursement for an admission to a hospital for psychiatric inpatient hospital services, the beneficiary shall meet medical necessity criteria set forth in Subsections (a)(1)-(2) below:

(1) One of the following diagnoses in theDiagnostic and Statistical Manual of Mental Disorders, Fourth Edition, DSM-IVE(1994), published by the American Psychiatric Association:

(A) Pervasive Developmental Disorders

(B) Disruptive Behavior and Attention Deficit Disorders

(C) Feeding and Eating Disorders of Infancy or Early Childhood

(D) Tic Disorders

(E) Elimination Disorders

(F) Other Disorders of Infancy, Childhood, or Adolescence

(G) Cognitive Disorders (only Dementias with Delusions, or Depressed Mood)

(H) Substance Induced Disorders, only with Psychotic, Mood, or Anxiety Disorder

(I) Schizophrenia and Other Psychotic Disorders

(J) Mood Disorders

(K) Anxiety Disorders

(L) Somatoform Disorders

(M) Dissociative Disorders

(N) Eating Disorders

(O) Intermittent Explosive Disorder

(P) Pyromania

(Q) Adjustment Disorders

(R) Personality Disorders

(2) Both the following criteria:

(A) Cannot be safely treated at a lower level of care, except that a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services for an acute psychiatric episode shall be considered to have met this criterion; and

(B) Requires psychiatric inpatient hospital services, as the result of a mental disorder, due to the indications in either Subsection (a)(2)(B)1. or 2. below:

1. Has symptoms or behaviors due to a mental disorder that (one of the following):

a. Represent a current danger to self or others, or significant property destruction.

b. Prevent the beneficiary from providing for, or utilizing, food, clothing or shelter.

c. Present a severe risk to the beneficiary's physical health.

d. Represent a recent, significant deterioration in ability to function.

2. Require admission for one of the following:

a. Further psychiatric evaluation.

b. Medication treatment.

c. Other treatment that can reasonably be provided only if the patient is hospitalized.

(b) Continued stay services in a hospital shall only be reimbursed when a beneficiary experiences one of the following:

(1) Continued presence of indications that meet the medical necessity criteria as specified in (a).

(2) Serious adverse reaction to medications, procedures or therapies requiring continued hospitalization.

(3) Presence of new indications that meet medical necessity criteria specified in (a).

(4) Need for continued medical evaluation or treatment that can only be provided if the beneficiary remains in a hospital.

Note: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

Mendocino County
Behavioral Health and Recovery Services
Acute Inpatient Hospitalization Audit Guidelines

Chapter 633, Statutes of 1994, Assembly Bill 757 consolidated the authorization of Fee-for-Service/Medi-Cal and Short-Doyle/Medi-Cal psychiatric inpatient hospital services at the county level. Under this program, the State Department of Health Care Services (DHCS) transferred the responsibility for the authorization of *Treatment Authorization Requests* (TARs) for psychiatric inpatient hospital services to the county's Mental Health Plan (MHP). The MHP authorizes psychiatric inpatient hospital service admissions, continued stay services and administrative days for all Medi-Cal recipients based on county of residence.

Medical Necessity, Admission, & Continued Stay Criteria

1. The beneficiary must have a DSM IV diagnosis medical necessity criteria
   CCR, title 9, chapter 11, sections Hospital Services. 1820.205(a)(1)(A) through 1820.205(a)(1)(R)

2. The beneficiary meet criteria in both a and b:

   a. Cannot be safely treated at a lower level of care, except that a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services for an acute psychiatric episode shall be considered to have met this criterion.

   b. Required psychiatric inpatient hospital services, as the result of a mental disorder, due to indications in either (1) or (2) below:

      1. Had symptoms or behaviors due to a mental disorder that (one of the following):

         a. Represented a current danger to self or others, or significant property destruction.
         b. Prevented the beneficiary from providing for, or utilizing food, clothing or shelter.
         c. Presented a severe risk to the beneficiary's physical health.
         d. Presented a recent, significant deterioration in ability to function.

      2. Required Admission for one of the following:
         a. Further psychiatric evaluation
         b. Medication treatment

c. Other treatment that could reasonably be provided only if beneficiary was hospitalized.

3. Did the beneficiary's continued stay services in a psychiatric inpatient hospital meet the following criteria:
   a. Continued presence of indications which meet the medical necessity criteria
   b. Serious adverse reactions to medication, procedures, or therapies requiring continued hospitalization.
   c. Presence of new indications which met medical necessity criteria.
   d. Need for continued medical evaluation or treatment that could only have been provided if the beneficiary remained in a psychiatric inpatient hospital.

Administrative Day Services

1. The following requirements must be met for reimbursement of Administrative Day Services:
   a. During the hospital stay, the beneficiary met medical necessity criteria for reimbursement of acute psychiatric inpatient hospital services.
   b. There was no appropriate, non-acute treatment facility within a reasonable geographic area.
   c. The hospital documented contact with a minimum of five (5) appropriate, non-acute treatment facilities per week subject to the following requirements
      1) The lack of placement options at appropriate, non-acute residential treatment facilities and the contacts made at appropriate facilities shall be documented to include but not be limited to:
         a. The status of the placement option
         b. The date of the contact
         c. Signature of the person making the contact

Reasons for Recoupment

A. Medical Necessity:

1. Documentation in the chart does not establish that the beneficiary has a diagnosis contained in Section 1820.205(a)(1)(A-R).
   CCR, title 9, chapter 11, section 1820.205(a)(1)(A-R)

2. Documentation in the medical record does not establish that the beneficiary could not be safely treated at a lower level of care, except a beneficiary who can

be safely treated with crisis residential treatment services or psychiatric health facility services shall be considered to have met this criterion.

3. Documentation in the chart does not establish that, as a result of a mental disorder listed in Section 1820.205(a)(1)(A-R), the beneficiary requires psychiatric inpatient hospital services for, at least, one of the following reasons:
   - Presence of symptoms or behaviors that represent a current danger to self or others, or significant property destruction.
   - Presence of symptoms or behaviors that prevent the beneficiary from providing for, or utilizing food, clothing or shelter.
   - Presence of symptoms or behaviors that present a severe risk to the beneficiary's physical health.
   - Presence of symptoms or behaviors that represent a recent, significant deterioration in ability to function.
   - Need for psychiatric evaluation, medication treatment, or other treatment that can reasonably be provided only if the beneficiary is in a psychiatric inpatient hospital.

   CCR, title 9, chapter 11, sections 1820.205(a)(2)(B) and 1820.205(b)

B. Administrative Day

1. Documentation in the chart does not establish that the beneficiary previously met medical necessity for acute psychiatric inpatient hospital service during the current hospital stay. CCR, title 9, chapter 11, sections 1820.220(j)(5) and 1820.225(d)(2)

2. Documentation provided by the Mental Health Plan (MHP) does not establish that there is no appropriate, non-acute residential treatment facility within a reasonable geographic area and the hospital does not document contacts with a minimum of five (5) appropriate, non-acute residential treatment facilities per week for placement of the beneficiary subject to the following requirements:

   a) The MHP or its designee may waive the requirement of five (5) contacts per week if there are fewer than five (5) appropriate, non-acute residential treatment facilities available as placement options for the beneficiary. In no case shall there be fewer than one (1) contact per week.

   b) The lack of placement options at appropriate, residential treatment facilities and the contacts made at appropriate treatment facilities shall be documented to include but not be limited to:

      i. The status of the placement option
      ii. The date of the contact
      iii. Signature of the person making the contact

      CCR, title 9, chapter 11, section 1820 230(d)(2)

C. Client Plan:

1. The beneficiary record does not contain a client plan.
   CFR, title 42, section 456.180; CCR, title 9, chapter 11, section 1820.210

2. The client plan was not signed by a physician.
   CFR, title 42, section 456.180; CCR, title 9, chapter 11, section 1820.210

D. Other:

1. A hospital day was claimed and paid (1) on which the beneficiary was not a patient in the hospital or (2) for the day of discharge, neither of which is reimbursable.
   CCR, title 9, chapter 11, section 1840.320(b)(1)(3).

CHART REVIEW WORKSHEET – SHORT-DOYLE/MEDI-CAL HOSPITAL SERVICES – DAY OF ADMISSION AND PLAN OF CARE

Beneficiary Name: _____ Admission Diagnosis: _____ Admit Date : _____

First UR Authorization Date: _____ _____ Legal Status: _____

Discharge Date: _____ Discharge Diagnosis: _____ Age on Admission: _____

Discharge Destination: _____ _____

Medical Necessity for Admission		
Is the discharge diagnosis from the included list in Title 9?	☐ Yes ☐ No	Comments:
Is there a qualifying impairment resulting from an included diagnosis?	☐ Yes ☐ No	☐ DTS ☐ DTO ☐ GD ☐ Other (Check the box(es) which indicate the HOSPITAL's alleged basis for medical necessity, then describe the behavioral/impairments which meet or do no meet medical necessity requirements for admission.)
Is there medical necessity for admission?	☐ Yes ☐ No If "No," refer to physician reviewer for evaluation.	Additional Comments Regarding Medical Necessity:
Physician reviewer's evaluation:	☐ Meets Medical Necessity for Admission ☐ Does NOT Meet Medical Necessity for Admission Comments: MD Signature: Date:	

Identifying Information	**Review information**	**Claim Review Summary**		
Hospital:	Reviewer/Date:	Total Days Claimed:	Acute Days Claimed:	Administrative Days Claimed:
Medical Record Number:	Reviewer/Date:	Total Days Approved:	Acute Days Approved:	Administrative Days Approved:
		Total Days Denied:	Acute Days Denied:	Administrative Days Denied:

Inpatient Plan of Care Required Elements		
Required Element*	**Is the Element Present?**	**Comments**
Diagnosis, symptoms, behaviors, complaints or complications which indicate need for admission to a psychiatric inpatient hospital.	☐ YES ☐ NO	
A description of the functional level of the beneficiary.	☐ YES ☐ NO	
Objectives which are behaviorally specific and/or behaviorally quantifiable.	☐ YES ☐ NO	
A description of proposed interventions Including durations.	☐ YES ☐ NO	
Orders for: • Medications • Treatments (Medical Treatments) • Restorative and rehabilitative Services (e.g., PT) • Activities • Therapies • Social services • Diet • Special procedures recommended for the and safety of the beneficiary	☐ YES ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO	
Plans for continuing care.	☐ YES ☐ NO	
Plans for discharge.	☐ YES ☐ NO	
Documentation of the beneficiary's degree of participation in and agreement with the plan.	☐ YES ☐ NO	
Documentation of the physician's establishment of the plan.	☐ YES ☐ NO	
Does the Plan of Care Contain All Required Elements?	☐ YES ☐ NO	

*For purposes of the presence or absence of documentation (except the physician's signature), the Physician's Admission Order Sheet (or comparable document) may be considered to be part of the Inpatient Plan of Care. Documentation of the physician's establishment of the Plan of Care must be indicated by his/her signature on the actual "Plan of Care" document-and not on the Physician's Admission Order Sheet.

Hospital Chart Audit Review Additional Acute Days

Date	Criteria	Summary	Meets Necessity	Physician Reviewer Evaluation	Comments/ Signature
	☐ DTS ☐ DTO ☐ GD		☐ YES ☐ NO	☐ Meets Medical Necessity ☐ Does Not meet Medical Necessity	
	☐ DTS ☐ DTO ☐ GD		☐ YES ☐ NO	☐ Meets Medical Necessity ☐ Does Not meet Medical Necessity	
	☐ DTS ☐ DTO ☐ GD		☐ YES ☐ NO	☐ Meets Medical Necessity ☐ Does Not meet Medical Necessity	
	☐ DTS ☐ DTO ☐ GD		☐ YES ☐ NO	☐ Meets Medical Necessity ☐ Does Not meet Medical Necessity	
	☐ DTS ☐ DTO ☐ GD		☐ YES ☐ NO	☐ Meets Medical Necessity ☐ Does Not meet Medical Necessity	

Reviewer: _____ **Date of Review:** _____

Reviewer: _____ **Date of Review:** _____

Monthly Access/Crisis/Phone Log

Organization Name Here

Period Listed Here

Combined			Crisis	Combined														Crisis					Access				
Staff taking Referral	Crisis or Access	Date of Contact or First Requested Service	Crisis: Time of Contact	Type of Contact	Beneficiaries Name	Initial Disposition (Type of Service Registered)	Date of Birth	Ethnicity	Gender	Stated City of Residence	Stated Method of Payment	Area Services were Provided	Provider List Requested / Provided	BHP Booked Requested / Provided	Interpreter Services Offered	Languages Services were provided in	Final Disposition Outcome	Time of face to face Crisis Assessment	Time from referral to face to face Crisis Assessment	5150	Criteria	TBS Offered (up to age 21)	Date of Billable Clinical Assessment	Days from Contact to First Assessment	Date of First Psychiatrist Appointment	Days from contact to first Psychiatric Appointment	Days From First Assessment to first billable Psychiatrist Appointment
Name	Crisis / Access	MM/DD/YY BOV/3	HH:MM AM/PM Military Time 1800	Phone / Walk in / Scheduled face to face	Last, First (MI)	Reason for call / visit	MM/DD/YY	Ethnicity or Unknown	Male, Female, Other	ITEXT	Medi-Cal or Insurance	What city clinician met client	YES / NO	YES / NO	YES / NO	Specify which languages	No Show / Placement	HH:MM AM/PM 1:00	Calculation HH:MM	Restricted Upload Criteria met and Unable to assess	DIS, DID, GID Criteria not met	YES / NO	MM/DD/YY 9/4/19	Calculation 16	MM/DD/YY 9/19/19	Calculation 20	Calculation 0

Monthly Hospitalization Log

Organization Name Here

Period Listed Here

Client Name	Chart #	Referring Agency	Hospital	Diagnosis	Criteria	City of Residence	Date of Birth	Ethnicity	Age	Gender	Date of Admission	Toxicology Screening	Principle Care Provider	Discharge Planner Assigned	Payment Status Type	Legal Status	Discharge Date	D/C Disposition
ast, First (MI)	XX-XXXX	OMG	SHH-DP	Delerial	G/D	[Text]	MM/DD/YY	[Text]	YY	Male	MM/DD/YY	[Text]	Last, First (MI) - Hospital Physicistst (License #)	Last, First (MI) - LCSW (License #)	[Text] –	[Text]	MM/DD/YY	Custody CPS
ast, First (MI)	XX-XXXX	OMG	Shore Vista	PTSD	G/D	[Text]	MM/DD/YY	[Text]	YY	Female	MM/DD/YY	[Text]	Last, First (MI) - Hospital Physicistst (License #)	Last, First (MI) - Physicistst (License #)	[Text]	[Text]	MM/DD/YY	Recovered
ast, First (MI)	XX-XXXX	RCS	NVSH	Schizoaffective	N/A	[Text]	MM/DD/YY	[Text]	YY	Male	MM/DD/YY	[Text]	Last, First (MI) - Hospital Physicistst (License #)	Last, First (MI) - Psychologist (License #)	[Text]	[Text]	MM/DD/YY	Davis GH
ast, First (MI)	XX-XXXX	OMG	SHH-Vallejo	Schizoaffective	D/O	[Text]	MM/DD/YY	[Text]	YY	Female	MM/DD/YY	[Text]	Last, First (MI) - Hospital Physicistst (License #)	Last, First (MI) - LCSW (License #)	[Text]	[Text]	MM/DD/YY	Ft. Bragg
ast, First (MI)	XX-XXXX	RCS	Telecare/Herbage-Oakland	Schizoaffective	D/S	[Text]	MM/DD/YY	[Text]	YY	Unidentified	MM/DD/YY	[Text]	Last, First (MI) - Hospital Physicistst (License #)	Last, First (MI) - Physicistst (License #)	[Text]	[Text]	MM/DD/YY	Ukiah Home
ast, First (MI)	XX-XXXX	NAPA COUNTY MH	Hudson Oaks	Mood DO NOS	D/S	[Text]	MM/DD/YY	[Text]	YY	Female	MM/DD/YY	[Text]	Last, First (MI) - Hospital Physicistst (License #)	Last, First (MI) - LCSW (License #)	[Text]	[Text]	MM/DD/YY	Home
ast, First (MI)	XX-XXXX	RCS	SHH Vallejo	Schizoaffective	N/A	[Text]	MM/DD/YY	[Text]	YY	Unidentified	MM/DD/YY	[Text]	Last, First (MI) - Hospital Physicistst (License #)	Last, First (MI) - Physicistst (License #)	[Text]	[Text]	MM/DD/YY	Willow Glen
ast, First (MI)	XX-XXXX	OMG	St. Helena-DP	Paranoid Schizoph	D/O	[Text]	MM/DD/YY	[Text]	YY	Male	MM/DD/YY	[Text]	Last, First (MI) - Hospital Physicistst (License #)	Last, First (MI) - LCSW (License #)	[Text]	[Text]	MM/DD/YY	Home