King County

King County Regional Support Network

King County Mental Health Plan

Policies and Procedures

Effective Date: February 2, 2015

QUICK REFERENCE
TABLE OF CONTENTS

I. THE KING COUNTY REGIONAL SUPPORT NETWORK (RSN) 25

II. THE KING COUNTY MENTAL HEALTH PLAN (KCMHP) 29

III. CLIENT RIGHTS 33

IV. FINANCIAL MANAGEMENT 105

V. CRISIS SERVICES LEVEL OF CARE 125

VI. OUTPATIENT SERVICES LEVEL OF CARE 143

VII. RESIDENTIAL AND SUPPORTIVE HOUSING SERVICES LEVEL OF CARE 265

VIII. INPATIENT SERVICES LEVEL OF CARE 309

IX. ADDITIONAL OUTPATIENT SERVICES 345

X. QUALITY MANAGEMENT AND EXTRAORDINARY OCCURRENCES 379

XI. CREDENTIALING AND CONTRACT MONITORING 473

XII. INFORMATION MANAGEMENT 489

XIII. PRIVACY AND SECURITY OF INFORMATION SYSTEMS 787

XIV. PROGRAM INTEGRITY 913

XV. DEFINITIONS 957

TABLE OF CONTENTS AND LIST OF ATTACHMENTS

I. THE KING COUNTY REGIONAL SUPPORT NETWORK 25

1.0 POLICY TITLE 25

2.0 PURPOSE 25

2.1 MISSION 25
2.2 GOAL 25
2.3 GUIDING PRINCIPLES 25

3.0 POLICY/PROCEDURES/RESPONSIBILITIES 26

3.1 KING COUNTY REGIONAL SUPPORT NETWORK (KCRSN) 26
3.2 SYSTEMS COORDINATION 27
3.3 RECOVERY EDUCATION FOR COMMUNITY AND PROVIDERS 27
3.4 STAKEHOLDER INPUT 27

4.0 REFERENCES 28

II. THE KING COUNTY MENTAL HEALTH PLAN (KCMHP) 29

1.0 POLICY TITLE 29

2.0 PURPOSE 29

2.1 PURPOSE 29
2.2 GOALS 30
2.3 SERVICE POPULATIONS 30

3.0 POLICY/PROCEDURES/RESPONSIBILITIES 30

3.1 THE REGIONAL SUPPORT NETWORK (RSN) 30
3.2 KING COUNTY MENTAL HEALTH PLAN (KCMHP) 30
3.3 PROVIDERS 30

4.0 REFERENCES 31

III. CLIENT RIGHTS 33

1.0 POLICY TITLE 33

2.0 PURPOSE 33

3.0 POLICY/PROCEDURES/RESPONSIBILITIES: INFORMATION REQUIREMENTS 33

3.1 AT INTAKE 33
3.2 UNDERSTANDABLE INFORMATION 34
3.3 IN CASE OF INCAPACITY 35
3.4 MULTILINGUAL NOTICE 35

4.0 CLIENT RIGHTS 35

4.1 INFORMING CLIENTS OF RIGHTS 35
4.2 HONORING CLIENT RIGHTS REGARDING PROTECTED HEALTH INFORMATION 36
4.3 POSTING OF CLIENT RIGHTS 36
4.4 PROCESSES FOR INFORMING CLIENTS OF RIGHTS 36
4.5 DOCUMENTATION OF UNDERSTANDING 37
4.6 CLIENT DISSASTISFACTION 37
4.7 EDUCATION OF STAFF ABOUT CLIENT RIGHTS 37
4.8 TREATMENT OF CLIENTS EXERCISING RIGHTS 37
4.9 MENTAL HEALTH ADVANCE DIRECTIVES 37
4.10 KCMHP HIPAA NOTICE OF PRIVACY PRACTICES 37
4.11 CLIENT CHOICE OF PROVIDERS 38
4.12 CLIENT NOTIFICATION OF TERMINATION 38
4.13 PROVIDING AGENCY/MHCP INFORMATION UPON CLIENT REQUEST 38

(III. CLIENT RIGHTS, CONTINUED)

4.14 CLIENTS WITH WASHINGTON APPLE HEALTH PLAN 39
4.15 INFORMED CONSENT 39
4.16 CLIENT SECOND OPINION 39
4.17 SECLUSION AND RESTRAINT 40

5.0 ADVANCE DIRECTIVES 41

5.1 RESPECTING AND UTILIZING CLIENT ADVANCE DIRECTIVES 41
5.2 COMPLIANCE WITH RELATED STATE AND FEDERAL LAW 41
5.3 STAFF EDUCATION 41
5.4 INFORMING CLIENTS ABOUT MENTAL HEALTH ADVANCE DIRECTIVES 41
5.5 REQUIREMENTS FOR CRISIS PLANS 41
5.6 CLIENT VOICE 42
5.7 NO PROVIDERS LIMITS ON IMPLEMENTATION 42
5.8 RIGHT TO COMPLAIN TO KCMHP ABOUT PROVIDER NON-COMPLIANCE 42
5.9 CLIENT'S RIGHT TO COMPLAIN TO MHD 42
5.10 NON-DISCRIMINATION 42

6.0 CLIENT SERVICES 42

6.1 ACCESS TO KCMHP CLIENT SERVICES STAFF 42
6.2 CLIENT SERVICES STAFF TELEPHONE RESPONSIBILITIES 42
6.3 MEDICAID AND NON-MEDICAID REFERRALS 42
6.4 COMPLAINTS, GRIEVANCES, APPEALS, AND FAIR HEARINGS 43
6.5 DOCUMENTATION AND MONITORING OF CONTACTS AND TRENDS 43

7.0 OMBUDS SERVICES 43

7.1 OMBUDS SERVICE FUNCTIONS 43
7.2 TRACKING AND REPORTING FOR QUALITY IMPROVEMENT 43
7.3 COORDINATION AND REFERRAL 43
7.4 DISPLAY OF BROCHURES 43
7.5 FACILITATION OF ACCESS 43

8.0 CLIENT COMPLAINTS 44

8.1 COMPLAINTS ABOUT MENTAL HEALTH SERVICES 44
8.2 COMPLAINTS ABOUT DISCRIMINATION 45

9.0 THE GRIEVANCE SYSTEM (GRIEVANCES AND APPEALS) 46

9.1 DEFINITION AND TEMPLATES 46
9.2 STATE-APPROVED DESCRIPTION OF GRIEVANCE SYSTEM 46
9.3 CLIENT'S RIGHTS DURING GRIEVANCE 46
9.4 REQUIREMENTS OF PROVIDERS AND KCMHP 46
9.5 CLIENT'S RIGHT TO ASSISTANCE WITH GRIEVANCE 46
9.6 CLIENT'S RIGHT TO INTERPRETER SERVICES 46
9.7 CLIENT'S RIGHT TO WRITTEN INFORMATION 46

10.0 GRIEVANCES 47

10.1 DEFINITION 47
10.2 CLIENT'S CHOICE OF ASSISTANCE 47
10.3 STEPS IN A PROVIDER GRIEVANCE 47
10.4 STEPS IN A KCMHP GRIEVANCE 49

11.0 MEDICAID CLIENT ACTION 51

11.1 DEFINITIONS OF ACTION, DENIAL, SUSPENSION, REDUCTION, TERMINATION, AND DISAGREEMENT 51
11.2 PROVIDER DECISIONS THAT ARE NOT ACTIONS 52
11.3 KCMHP AUTHORIZATIONS THAT MAY CONSTITUTE AN ACTION 52

12.0 NOTICE OF DETERMINATION 54

12.1 MEDICAID AND NON-MEDICAID NOTICES OF DETERMINATION 54
12.2 STATE-FUNDED NOTICES OF DETERMINATION 54

(III. CLIENT RIGHTS, CONTINUED)

13.0 NOTICES TO CHILDREN WITH A "D" COUPON 56

14.0 MEDICAID CLIENT NOTICE OF ACTION 56

14.1 FORM MAILED AND SENT ELECTRONICALLY 56
14.2 FORM AND CONTENTS OF NOTICE 56
14.3 RESPONSIBILITY FOR IDENTIFYING WHEN A NOTICE OF ACTION IS REQUIRED 57
14.4 COPY TO PROVIDER THAT HAS MADE AUTHORIZATION REQUEST 58
14.5 ACCURATE PROVIDER CLAIMS AFTER TERMINATION OF BENEFIT 58
14.6 CRISIS CARE DURING CLIENT APPEAL 58
14.7 TIME FRAMES FOR SENDING NOTICES 59
14.8 SUMMARY OF NOTICE REQUIREMENTS 60

15.0 MEDICAID CLIENT APPEAL (IN RESPONSE TO A NOTICE OF ACTION) 60

15.1 DEFINITION OF APPEAL 60
15.2 STEPS IN AN APPEAL 61
15.3 STATE-FUNDED CLIENTS FILE GRIEVANCES RATHER THAN APPEALS 63

16.0 CONTINUATION OF SERVICES DURING THE GRIEVANCE OR APPEAL PROCESSES 64

16.1 CONTINUATION OF PREVIOUSLY AUTHORIZED SERVICES 64
16.2 SERVICES NOT CONTINUED DURING APPEAL OR GRIEVANCE FOR DENIAL OF SERVICES 64
16.3 CONDITIONS FOR CONTINUATION OF PREVIOUSLY AUTHORIZED SERVICES (MEDICAID) 64
16.4 CONDITIONS FOR CONTINUATION OF PREVIOUSLY AUTHORIZED SERVICES (STATE-FUNDED) 64
16.5 CLIENT'S POSSIBLE FINANCIAL RESPONSIBILTY FOR CONTINUATION OF SERVICES 64
16.6 DURATION OF CONTINUATION OF SERVICES 65
16.7 WHEN GRIEVANCES OR APPEALS FOR PREVIOUSLY AUTHORIZED SERVICES ARE UPHELD/OVERTURNED 65
16.8 WHEN GRIEVANCES OR APPEALS FOR DENIAL OF SERVICES ARE UPHELD, SERVICES NOT RECEIVED 65
16.9 WHEN GRIEVANCES OR APPEALS FOR DENIAL OF SERVICES ARE UPHELD, SERVICES DELIVERED 66
16.10 CRISIS SYSTEM AVAILABLE DURING GRIEVANCE AND APPEAL PROCESSES 66

17.0 STATE FAIR HEARINGS 66

17.1 RIGHT TO USE PRE-HEARING AND ADMINISTRATIVE HEARING PROCESSES 66
17.2 WHEN A FAIR HEARING MAY BE REQUESTED 66
17.3 TOLL FREE NUMBER FOR INITIATING HEARINGS 66
17.4 CLIENTS MAY REQUEST ASSISTANCE FROM SEVERAL SOURCES 66
17.5 FILING TIMELINE 66
17.6 EVIDENCE AND/OR ALLEGATIONS OF FACT IN WRITING OR IN PERSON 66
17.7 DECISIONS ARE BINDING 66
17.8 CONTINUATION OF SERVICES DURING HEARING PROCESS 66
17.9 KCMHP PARTICIPATION 66

18.0 PROVIDER TRAINING 66

18.1 DURING KCMHP STAFF/PROVIDER MEETINGS 66
18.2 ADDITIONAL TRAINING UPON REQUEST 66

19.0 COMPLIANCE MONITORING AND REPORTS 67

19.1 KCMHP OVERSIGHT DURING GRIEVANCE OR APPEAL PROCESS 67
19.2 KCMHP MONITORS COMPLIANCE 67
19.3 KCMHP MONITORS IMPLEMENTATION 67
19.4 TIMELINE FOR PROVIDER DOCUMENTATION OF COMPLIANCE 67
19.5 FOLLOW-UP REGARDING RETALIATION 67
19.6 RETENTION AND REVIEW OF DOCUMENTATION ON GRIEVANCES AND APPEALS 67
19.7 PROVIDER REPORTING TO KCMHP 67
19.8 REQUIREMENTS FOR KCMHP'S REPORTS TO MHD 67

20.0 LIST OF ATTACHMENTS 67

21.0 REFERENCES 68

(III. CLIENT RIGHTS, CONTINUED)

ATTACHMENTS:

Client Rights - Outpatient Services ..... *Attachment A*
Client Rights: How to Promote and Protect Them ..... *Attachment A-1*
Mental Health Advance Directives: What Clinicians Need to Know ..... *Attachment A-2*
Grievance System Reporting Instructions ..... *Attachment B-1a*
Grievance Report – Medicaid-Funded Services ..... *Attachment B-1b*
Grievance Report – State-Funded Services ..... *Attachment B-1c*
Grievance Procedure Tracking Form ..... *Attachment B-2*
Notice of Determination for Authorization of Services ..... *Attachment C*
Notice of Action for Disagreement with Treatment Plan ..... *Attachment D*
Notice of Determination for Denial, Reduction, Termination, or Suspension of Services for State-Funded Clients ..... *Attachment E*
Notice of Action for Medicaid Clients ..... *Attachment F*
Accessing Medical Care for EPSDT Clients ..... *Attachment G*
When to send a Notice of Determination or Notice of Action ..... *Attachment H*
Failure to Offer Intake or Request Authorization Form ..... *Attachment I*

IV. FINANCIAL MANAGEMENT 105

1.0 POLICY TITLE 105

2.0 PURPOSE 105

3.0 POLICY/PROCEDURES/RESPONSIBILITIES 105

3.1 CASE RATE MODEL 105
3.2 BENEFIT PACKAGE 106
3.3 PROVIDER CASE RATE REIMBURSEMENT 106
3.4 CULTURAL DIFFERENTIAL AND LANGUAGE DIFFERENTIAL 106
3.5 RECOVERY INCENTIVES 108
3.6 CASE RATE CHANGE 108
3.7 PROVIDER CHANGES 109
3.8 PROVIDER REIMBURSEMENT 109
3.9 PAYMENT OF INVOICES 111
3.10 FINANCIAL ADJUSTMENT 111
3.11 FINANCIAL EXCEPTION TO POLICY 113
3.12 NON-MEDICAID RESOURCES 115
3.13 COORDINATION OF OTHER RESOURCES 115
3.14 SPENDDOWN 117
3.15 CLIENT PARTICPATION PAYMENTS 117
3.16 EXTRAORDINARY TREATMENT PLAN (ETP) PAYMENTS 117
3.17 HOMELESS OUTREACH STABILIZATION AND TREATMENT (HOST) CLIENTS 117
3.18 MEDICAID PERSONAL CARE 117
3.19 CLAIMS FOR OUT-OF-AREA EMERGENCY SERVICES AND OUT-OF-NETWORK SERVICES 118
3.20 UNIFORM COST REPORTING 118
3.21 AUDITED ANNUAL FINANCIAL STATEMENTS 119
3.22 MEDICAID FRAUD, MEDICAID WASTE, AND MEDICAID ABUSE 119
3.23 ADMINISTRATIVE SERVICES 120
3.24 KCMHP RESERVE ACCOUNTS 120

4.0 LIST OF ATTACHMENTS 120

5.0 REFERENCES 121

ATTACHMENTS:

Case Rates ..... *Attachment A*
Scenarios for MIDD Authorizations ..... *Attachment B*

V. CRISIS SERVICES LEVEL OF CARE 125

1.0 POLICY TITLE 125

2.0 PURPOSE 125

3.0 ELIGIBILITY 125

3.1 ELIGIBILITY FOR CRISIS SERVICES 125
3.2 MEDICAL NECESSITY CRITERIA 126
3.3 AUTHORIZATION 126
3.4 CONTINUING STAY CRITERIA 126
3.5 TERMINATION AND DISCHARGE CRITERIA 127
3.6 NOTICES 127
3.7 PROVIDER APPEALS 127

4.0 POLICY/PROCEDURES/RESPONSIBILITIES 127

4.1 CRISIS SERVICES WHEN AUTHORIZED TO OUTPATIENT BENEFIT 127
4.2 STATUTORY REQUIREMENTS FOR SAFETY OF CRISIS WORKERS 127
4.3 CLIENTS IN CRISIS MUST BE ABLE TO UNDERSTAND INFORMATION PROVIDED 127
4.4 CRISIS SERVICES FOR PEOPLE WITHOUT AN OUTPATIENT BENEFIT 127
4.5 TIME FRAMES FOR RESPONSE 129
4.6 DOCUMENTATION REQUIREMENTS 129
4.7 CCS AND PROVIDER USE OF CO-OCCURRING DISORDER SCREENING/ASSESSMENT TOOL 130
4.8 PARTICIPATION IN EMERGENCY/DISASTER PREPAREDNESS 130

5.0 INFORMATION SYSTEMS BUSINESS RULES 130

6.0 FINANCIAL BUSINESS RULES 130

7.0 LIST OF ATTACHMENTS 130

8.0 REFERENCES 130

ATTACHMENTS:

Standardized Initial Crisis Screening Protocols (SICSP) ..... Attachment A
Next Day Appointment (NDA) and Non Emergent Outreach (NEO) Minimum Requirements for Crisis Response System ..... Attachment B
Intensive Stabilization Services Referral Form ..... Attachment C

VI. OUTPATIENT SERVICES LEVEL OF CARE 143

1.0 POLICY TITLE 143

2.0 PURPOSE 143

3.0 POLICY/PROCEDURES/RESPONSIBILITIES FOR ACCESS TO SERVICES 143

3.1 FINANCIAL ELIGIBILITY 143
3.1.1 MEDICAID ELIGIBILITY 143
3.1.2 MEDICARE ELIGIBILITY 145
3.1.3 NON-MEDICAID ELIGIBILITY 145
3.2 MEDICAL NECESSITY 146
3.2.1 REQUIREMENT TO MEET ACCESS TO CARE CRITERIA 146
3.2.2 ACCESS TO CARE CRITERIA 146
3.2.3 DOCUMENTING AND REPORTING DIAGNOSES 147
3.2.4 REFERRALS FOR PEOPLE WITH WASHINGTON APPLE HEALTH 148
3.2.5 PRIORITIES FOR PERSONS WHO DO NOT HAVE MEDICAID 148
3.3 AUTHORIZATION FOR OUTPATIENT LEVEL OF CARE 151
3.3.1 OUTPATIENT BENEFIT PACKAGE CHARACTERISTICS 151
3.3.2 AUTHORIZATION REQUESTS SUBMITTED ELECTRONICALLY 152
3.4 TIMELINES FOR AUTHORIZATIONS AND INTIATION OF SERVICES 152
3.4.1 INTAKE APPOINTMENT 152
3.4.2 AUTHORIZATION REQUESTS 153
3.4.3 AUTHORIZATION DECISIONS 153
3.4.4 INITIATION OF ROUTINE SERVICES 154

(VI. OUTPATIENT SERVICES LEVEL OF CARE, CONTINUED)

3.4.5 EXPEDITED AUTHORIZATIONS AND SERVICES 155
3.4.6 CLIENT CHOICE OF PROVIDERS 155
3.5 KCMHP CLINICAL STAFF REVIEW OF CERTAIN AUTHORIZATION REQUESTS 155
3.5.1 REQUESTS SUBJECT TO MANUAL REVIEW 155
3.5.2 REVIEW OF 3B CASE RATE AND OTHER REQUESTS 155
3.5.3 CHANGES RESULTING FROM REVIEWS 156
3.5.4 PROCEDURE FOR MANUAL REVIEW 156
3.5.5 TIMELINE FOR SUBMISSION OF INITIAL CLINICAL DOCUMENTATION 157
3.5.6 TIMELINE/PROCESS FOR INITIAL KCMHP REVIEW 157
3.5.7 TIMELINE/PROCESS FOR ADDITIONAL INFORMATION 157
3.5.8 TIMELINE/PROCESS FOR KCMHP REVIEW OF ADDITIONAL INFORMATION 157
3.5.9 TIMELINE/PROCESS FOR FURTHER ADDITIONAL INFORMATION 157
3.5.10 TIMELINE/PROCESS FOR KCMHP REVIEW OF FURTHER ADDITIONAL INFORMATION 157
3.5.11 PROCEDURE IF CLINICAL DOCUMENTATION IS NOT RECEIVED 158
3.5.12 RELEVANT ISSUES FOR CASE DISCUSSION 158
3.6 CONTINUING STAY CRITERIA 158
3.6.1 DEFINITION 158
3.6.2 FACE-TO-FACE CLIENT CONTACT REQUIREMENT 158
3.6.3 ASSESSMENT BY MHP NOT REQUIRED IF PREVIOUS INTAKE PERFORMED BY MHP 158
3.6.4 CONTINUED STAY CRITERIA FOR OUTPATIENT SERVICES 158
3.6.5 CONDITIONS FOR REQUESTING NEW OUTPATIENT AUTHORIZATION 159
3.6.6 TIMELINE FOR AUTHORIZATION REQUEST 159
3.6.7 TIMELINE FOR ASSESSMENT DATE 159
3.6.8 PROCEDURES SAME AS INITIAL REQUEST 159
3.6.9 KCMHP EVALUATION OF EFFECTIVENESS AND RECOMMENDATION OF CHANGES 159
3.7 TERMINATION 159
3.7.1 DEFINITION 159
3.7.2 PAYMENT OF TERMINATED BENEFIT 159
3.7.3 CIRCUMSTANCES WHEN TERMINATION REQUEST IS REQUIRED 159
3.7.4 REASONS FOR OPTIONAL TERMINATION 160
3.7.5 PROCESS FOR TERMINATION DUE TO PROVIDER CHANGE 160
3.7.6 EFFECTIVE DATE OF TERMINATION 161
3.8 PROVIDER APPEALS 161
3.8.1 APPEALS ALLOWED 161
3.8.2 STAGES OF APPEAL PROCESS 161
3.8.3 TRACKING OF PROVIDER APPEALS 162
3.8.4 PROVISION OF SERVICES DURING APPEAL PROCESS 162
3.9 NOTICES FOR CLIENTS 162
3.9.1 CIRCUMSTANCES WHEN KCMHP WILL NOTIFY CLIENTS 162
3.9.2 ADDITIONAL INFORMATION REGARDING CLIENT NOTIFICATION 163
3.10 CLIENT APPEALS 163
3.10.1 APPEALS OF NOTICES OF ACTION 163
3.10.2 GRIEVANCES OF NOTICES OF DETERMINATION 163
3.10.3 PROCEDURES FOR APPEALS AND GRIEVANCES 163
3.11 EXTRAORDINARY TREATMENT PLAN (ETP) APPROVAL REQUESTS 163

4.0 POLICY/PROCEDURES/RESPONSIBILITIES FOR SERVICES 166

4.1 SERVICES 166
4.1.1 SERVICE VALUES 166
4.1.2 STATE PLAN MODALITIES 166
4.1.3 ADDITIONAL SERVICES AVAILABLE 167
4.1.4 INTAKE EVALUATION REQUIREMENTS 167
4.1.5 DEVELOPMENTAL SCREENING AND ASSESSMENT 169
4.1.6 INDIVIDUAL SERVICE PLAN (ISP) DEVELOPMENT AND REVIEW 169
4.1.7 CLINICAL RECORD CONTENT 172
4.1.8 CRISIS SERVICES FOR CLIENTS WITH OUTPATIENT BENEFITS 175
4.1.9 CRISIS PLANS 178
4.1.10 SERVICES FOR CLIENTS IN HOSPITAL EMERGENCY DEPARTMENTS 180

(VI. OUTPATIENT SERVICES LEVEL OF CARE, CONTINUED)

4.1.11 SERVICES FOR CLIENTS PRIOR TO AND FOLLOWING HOSPITALIZATION 181
4.1.12 SERVICES FOR CLIENTS ON "LESS RESTRICTIVE" COURT ORDERS 183
4.1.13 SERVICES FOR CLIENTS IN JAIL 183
4.1.14 MEDICATION EVALUATION SERVICES 184
4.1.15 COORDINATION OF CARE WITH PRIMARY CARE AND CHEMICAL DEPENDENCY PROVIDERS 184
4.1.16 EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) 184
4.1.17 VOCATIONAL SERVICES 185
4.2 DOCUMENTATION REQUIREMENTS 186
4.2.1 ALL CLINICAL SERVICES MUST BE RECORDED 186
4.2.2 DOCUMENTATION FOR EACH UNIT OF SERVICE 186
4.2.3 JUSTIFICATION OF SERVICE CODE 186
4.2.4 LEGIBILITY 186
4.2.5 PROGRESS NOTES REFERENCE CLINICAL STATUS AND RESPONSE TO ISP 186
4.2.6 DOCUMENTATION OF CRISIS SERVICES 186
4.3 MANAGEMENT OF SERVICE UTILIZATION 186
4.3.1 PROVIDERS' UTILIZATION MANAGEMENT PROCESS 186
4.3.2 PROVIDER RESPONSE TO KCMHP LOW SERVICE UTILIZATION REPORTS 187
4.3.3 PROTOCOLS FOR MANAGEMENT OF CLIENTS WHO FREQUENTLY USE COSTLY SERVICES 187
4.3.4 KCMHP HIGH UTILIZATION REPORT 187
4.3.5 KCMHP NOTIFIES LIAISONS 187

5.0 INFORMATION SYSTEMS BUSINESS RULES 187

5.1 PROVIDER'S RESPONSIBILITY FOR COMPLETE AND ACCURATE DATA 187
5.2 ELIGIBILITY 188
5.2.1 MEDICAID STATUS REQUIREMENTS 188
5.2.2 COVERAGE TYPES 189
5.3 AUTHORIZATION 189
5.3.1 DATA STATUS AND TIMELINES 189
5.3.2 REQUEST FOR SERVICE 190
5.4 AUTHORIZATION PROCESS 192
5.4.1 AUTHORIZATION REQUESTS PROCESSED WITHIN 24 HOURS 192
5.4.2 TESTING OF DATA 192
5.4.3 STATUS CODES, CASE RATES, AND PAYMENT 193
5.4.4 TESTING AND RECALCULATION OF ELIGIBILITY, MEDICAL NECESSITY, AND CASE RATE 193
5.4.5 IN CASE OF INSUFFICIENT INFORMATION 193
5.4.6 RETROACTIVE AUTHORIZATION 193
5.5 AUTHORIZATION STATUS CODES 193
5.5.1 TABLE OF CODES 193
5.5.2 DAILY REPORTS OF CHANGES 194
5.5.3 ERROR REPORTS 194
5.6 CASE RATE CALCULATION 194
5.6.1 BASIS FOR CALCULATION 194
5.6.2 CHANGES IN DATA LEAD TO RECALCULATION OF CASE RATE 194
5.7 CULTURAL DIFFERENTIAL 194
5.7.1 INCREASED CASE RATES FOR CERTAIN POPULATIONS 194
5.7.2 DIFFERENTIAL APPLIED ONLY AFTER SPECIALIST EVALUATION OR CONSULTATION 194
5.7.3 HOMEBOUND AND HEARING-IMPAIRED CLIENTS 195
5.8 VALIDATION OF CLINICAL CRITERIA FOR A CASE RATE 195
5.8.1 REASON FOR VALIDATION 195
5.8.2 ALL AUTHORIZED OUTPATIENT BENEFITS HAVE CC VALIDATION STATUS 195
5.8.3 CC VALIDATION STATUS 0 195
5.8.4 ALL OTHER CODES INDICATE REASON CRITERIA NOT MET 195
5.8.5 CASE RATE HIGH INDICATOR 195
5.8.6 COMBINATION OF CC STATUS NOT 0 AND NULL CASE RATE VALUE 195
5.8.7 SECOND MONTH CUTOFF DATE: CANCELLATION OF INCOMPLETE AUTHORIZATION REQUESTS 195
5.8.8 THIRD MONTH CUTOFF DATE: DEADLINE FOR MAKING CHANGES TO CLINICAL DATA 196
5.8.9 CASE RATE CALCULATION CHANGES REPORTED TO PROVIDERS 196

(VI. OUTPATIENT SERVICES LEVEL OF CARE, CONTINUED)

5.9 NON-MEDICAID AUTHORIZATION 196
5.9.1 FIRST TESTED FOR FINANCIAL AND CLINICAL ELIGIBILITY 196
5.9.2 NON-MEDICAID PRIORITIES IMMEDIATELY AUTHORIZED; OTHERS MAY BE WAITLISTED 196
5.9.3 NON-MEDICAID WAITLIST MANAGEMENT 196
5.9.4 CANCELLATION OF WAITLIST OUTPAITENT AUTHORIZATION REQUESTS 197
5.9.5 AUTHORIZATION RESPONSE RECORD 197
5.9.6 CASE RATE CHANGE REQUESTS 197
5.10 CONTINUING STAY REQUESTS 198
5.11 TERMINATIONS 199
5.11.1 PROVIDER REQUEST FOR TERMINATION 199
5.11.2 DUE TO PROLONGED HOSPITAL STAY 199
5.11.3 DUE TO PROLONGED DETENTION/INCARCERATION 199
5.11.4 PAYMENT FOR TERMINATED AUTHORIZATIONS 199
5.12 CANCELLATIONS 199
5.12.1 PROVIDER REQUEST FOR CANCELLATION 199
5.12.2 SUBJECT TO RECOUPMENT 200

6.0 FINANCIAL BUSINESS RULES 200

6.1 CASE RATES 200
6.1.1 PAYMENTS ACCORDING TO CASE RATE MODEL 200
6.1.2 MONTHLY PREPAYMENTS 200
6.1.3 EXPECTATIONS WHEN CLIENT HAS OTHER FUNDING SOURCES 200
6.1.4 PROVIDERS SHARING SERVICES 200
6.1.5 PAYMENT OF SUBCONTRACTORS 201
6.1.6 ALLOCATION OF RESOURCES FOR CLIENTS NOT COVERED BY MEDICAID 201

7.0 LIST OF ATTACHMENTS 202

8.0 REFERENCES 202

ATTACHMENTS:

Access to Care Standards ..... *Attachment A*
Diagnosis B Criteria for Children Age 6 and Older ..... *Attachment B*
Diagnosis B Criteria for Adults and Older Adults ..... *Attachment C*
Non-Medicaid Outpatient Request Form (for agencies with a Non-Medicaid allocation ..... *Attachment D-1*
Non-Medicaid Outpatient Request Form (for agencies without a Non-Medicaid allocation ..... *Attachment D-2*
Non-Medicaid Access Diagnosis Codes ..... *Attachment E*
Clinical Case Rate Criteria ..... *Attachment F*
Clinical Case Rate Criteria Decision Tree ..... *Attachment G*
Assessment Scales (PIRGAS, CGAS, GAF) ..... *Attachment H*
Checklist for Case Review ..... *Attachment I*
ETP Request Form ..... *Attachment J*
State Plan Modalities ..... *Attachment K*
Co-Occurring Disorder Screening and Assessment ..... *Attachment L*
Crisis Plan Form ..... *Attachment M*
Jail Form ..... *Attachment N*
Conditions and Circumstances Impacting Behavior ..... *Attachment O*
Determining King County RSN Eligibility for People Who Live in Zip Codes that Overlap Counties ..... *Attachment P*

VII. RESIDENTIAL AND SUPPORTIVE HOUSING SERVICES LEVEL OF CARE 265

1.0 POLICY TITLE 265

2.0 PURPOSE 265

2.1 RESIDENTIAL SERVICES 265
2.1.1 LONG-TERM REHABILITATION (LTR) SERVICES 265
2.1.2 SUPERVISED LIVING (SL) SERVICES 265

(VII. RESIDENTIAL AND SUPPORTIVE HOUSING SERVICES LEVEL OF CARE, CONTINUED)

2.2 SUPPORTIVE HOUSING SERVICES 265
2.2.1 STANDARD SUPPORTIVE HOUSING (SSH) SERVICES 265

3.0 POLICY/PROCEDURES/RESPONSIBILITIES FOR ACCESS TO SERVICES 265

3.1 FINANCIAL ELIGIBILITY 265
3.1.1 SAME AS FOR OUTPATIENT SERVICES 265
3.1.2 AVAILABLE ONLY TO CLIENTS OVER AGE 18 266
3.2 MEDICAL NECESSITY 266
3.2.1 ELIGIBILITY CRITERIA AND EXPECTATIONS 266
3.2.2 DEMONSTRATED NEED FOR INTENSIVE SERVICES 266
3.3 AUTHORIZATION FOR RESIDENTIAL AND SUPPORTIVE HOUSING SERVICES 266
3.3.1 SCREENING INDIVIDUALS IN INPATIENT CARE 266
3.3.2 SCREENING INDIVIDUALS OUTPATIENT CARE 266
3.3.3 DOCUMENTED PRE-APPROVAL 267
3.3.4 FIRST AND SECOND PRIORITY GROUPS 267
3.3.5 SCREENING PROCESS AND DOCUMENTS 268
3.3.6 ABBREVIATED SCREENINGS FOR CERTAIN SITUATIONS 269
3.3.7 WRITTEN CERTIFICATION OF REVIEW AND APPROVAL 269
3.3.8 AUTHORIZATION FOLLOWING THE SCREENING 270
3.4 CONTINUING STAY CRITERIA 270
3.4.1 SL AND LTR 270
3.4.2 SSH 270
3.5 TERMINATION AND DISCHARGE 271
3.5.1 WHEN TERMINATION REQUEST IS REQUIRED 271
3.5.2 PAYMENT OF TERMINATED BENEFIT 272
3.5.3 CONTINUATION OF SERVICES DURING TRANSFER 272
3.5.4 WHEN A CLIENT LEAVES LTR OR SL FOR MORE THAN FIVE DAYS 272
3.5.5 WHEN A CLIENT LEAVES SSH 273
3.5.6 DISCHARGE 273
3.6 CLIENT NOTICE AND APPEALS 273
3.6.1 NOTICE OF ACTION REQUIREMENT 273
3.6.2 ACTIONS FOR RESIDENTIAL AND SUPPORTIVE HOUSING SERVICES 273
3.6.3 EVENTS THAT ARE NOT ACTIONS 273
3.6.4 CHANGING TO NON-RESIDENTIAL OUTPATIENT SERVICES ONLY 273
3.6.5 NOTICE REQUIREMENTS 273
3.6.6 RIGHTS TO APPEALS, GRIEVANCES, STATE FAIR HEARINGS, CONTINUATION OF SERVICES 273
3.6.7 PROCEDURE FOR SENDING NOTICES 273
3.7 PROVIDER APPEALS 274

4.0 POLICY/PROCEDURES/RESPONSIBILITIES FOR SERVICES 274

4.1 SERVICES 274
4.1.1 SERVICE VALUES 274
4.1.2 LONG-TERM REHABILITATION (LTR) SERVICE DEFINITION 274
4.1.3 SUPERVISED LIVING (SL) SERVICE DEFINITION 274
4.1.4 STANDARD SUPPORTIVE HOUSING (SSH) SERVICE DEFINITION 275
4.1.5 INDIVIDUAL SERVICE PLAN (ISP) 275
4.1.6 CRISIS PLAN 276
4.2 DOCUMENTATION REQUIREMENTS 276

5.0 INFORMATION SYSTEMS BUSINESS RULES 276

5.1 ACCURACY AND COMPLETENESS OF DATA 276
5.2 AUTHORIZATION DATA STATUS AND TIMELINES 276
5.3 AUTHORIZATION PROCESS 277
5.3.1 INITIAL AUTHORIZATION DATA TIMELINE 277
5.3.2 PROCESSING TIMELINE 277
5.3.3 DATA TESTING SSH AUTHORIZATIONS 277
5.3.4 ELIGIBILITY AND MEDICAL NECESSITY TESTING FOR ISH AND SSH AUTHORIZATIONS 277
5.3.5 RETROACTIVE AUTHORIZATION 277

(VII. RESIDENTIAL AND SUPPORTIVE HOUSING SERVICES LEVEL OF CARE, CONTINUED)

5.4 AUTHORIZATION STATUS CODES 277
5.4.1 TABLE OF STATUS CODES 277
5.4.2 DAILY REPORTS FOR PROVIDERS 278
5.4.3 DAILY ERROR REPORTS 278
5.5 CONTINUING STAY REQUIREMENTS FOR RENEWAL OF AN EXISTING SSH AUTHORIZATION 278
5.6 TERMINATIONS 278
5.6.1 PROVIDER REQUEST FOR TERMINATIONS 278
5.6.2 PAYMENT FOR TERMINATED SUPPORTIVE HOUSING AUTHORIZATIONS 278
5.7 CANCELLATIONS 279
5.7.1 PROVIDER REQUEST FOR CANCELLATION 279

6.0 FINANCIAL BUSINESS RULES 279

6.1 DAILY RATES 279
6.1.1 PAYMENTS ACCORDING TO DAILY RATE 279
6.1.2 SERVICE TYPE DEFINES PAYMENT RATE 279
6.1.3 MONTHLY PREPAYMENT 279
6.2 SUBMISSION OF START AND EXIT DATES 279
6.2.1 START DATE DEFINITION 279
6.2.2 START DATE NOT PRIOR TO CERTIFICATION DATE 279
6.2.3 EXIT DATE DEFINITION 279
6.2.4 RESIDENTIAL STAFF RESPONSIBILITIES WHEN CLIENT LEAVES 279
6.2.5 DEADLINE FOR EXIT DATE SUBMISSION 280
6.3 CLIENT PARTICIPATION 280
6.4 PAYMENT OF SUBCONTRACTORS 280

7.0 LIST OF ATTACHMENTS 280

8.0 REFERENCES 280

ATTACHMENTS:

Residential Services Screening Form ..... Attachment A
LTR Placement Criteria ..... Attachment B
SL Placement Criteria ..... Attachment C
Standard Supportive Housing Residential Treatment Services Placement Criteria ..... Attachment D
Residential and Supportive Housing Services Placement Request Form ..... Attachment E
Residential Annual Review Form ..... Attachment F
SL and LTR Continued Stay Criteria ..... Attachment G
Residential Services Tracking ..... Attachment H
SSH Transition Form ..... Attachment I
Residential Absence Authorization ..... Attachment J

VIII. INPATIENT SERVICES LEVEL OF CARE 309

1.0 POLICY TITLE 309

2.0 PURPOSE 309

3.0 POLICY/PROCEDURES/RESPONSIBILITIES FOR ACCESS TO SERVICES 309

3.1 FINANCIAL ELIGIBILITY 309
3.1.1 VOLUNTARY INPATIENT CARE 309
3.1.2 INVOLUNTARY INPATIENT CARE 310
3.1.3 STATE HOSPITAL CARE 310
3.1.4 CHILDREN'S LONG-TERM INPATIENT PROGRAMS 310
3.2 MEDICAL NECESSITY 310
3.2.1 VOLUNTARY INPATIENT CARE 310
3.2.2 INVOLUNTARY INPATIENT CARE 312
3.3 AUTHORIZATION FOR THE INPATIENT LEVEL OF CARE 312
3.3.1 VOLUNTARY INPATIENT CARE 312
3.3.1.A TIMELINE FOR EVALUATION 312
3.3.1.B BACKDATING AUTHORIZATIONS 313

(VIII. INPATIENT SERVICES LEVEL OF CARE, CONTINUED)

3.3.1.C Determining coverage and alternatives 313
3.3.1.D Determination of medical necessity 313
3.3.1.E Authorization under special circumstances approved by KCMHP 314
3.3.1.F Number of days of initial authorization 314
3.3.1.G Procedure for admission authorization 315
3.3.1.H Timelines for authorization decisions 315
3.3.1.I Timelines for responses to authorization requests 316
3.3.1.J Deferred decision in absence of medical necessity information 316
3.3.1.K No termination, suspension, or reduction 316
3.3.1.L Authorization expiration time frame 316
3.3.1.M Denials 316
3.3.1.N Expedited reviews 316
3.3.1.O Conditions for new authorization request 317
3.3.1.P Special circumstances 317
3.3.1.Q Retrospective authorizations of voluntary admissions 320
3.3.2 Involuntary inpatient care 322
3.4 Continuing stay criteria and authorization of extensions 322
3.4.1 Definition 322
3.4.2 Voluntary admissions 322
3.4.3 Involuntary admissions 324
3.4.4 KCMHP assistance with planning upon third length of stay extension requests 324
3.5 Discharge and termination 324
3.5.1 Discharge when client does not meet medical necessity 324
3.5.2 Discharge prior to authorization expiration 324
3.5.3 Notification of care authorizer upon discharge 324
3.6 Provider appeals 324
3.6.1 Appeals allowed 324
3.6.2 Situations for appeals 325
3.6.3 No appeal for administrative days 325
3.6.4 Timelines for provider appeal requests 325
3.6.5 Required information for appeal request 325
3.6.6 Where to submit appeal requests 325
3.6.7 Decision based on medical record documentation 325
3.6.8 Factors beyond the original reasons for denial 325
3.6.9 Appeal decision by KCMHP Medical Director 325
3.6.10 Written response after appeal decision 325
3.6.11 Appeal decisions final and binding 326
3.6.12 Failure of RSN to follow state published requirements 326
3.7 Notices of Action and appeals 326
3.7.1 Adverse actions requiring a notice of action 326
3.7.2 What is not considered an adverse action 326
3.7.3 When an adverse action occurs 327
3.7.4 The right to appeal a notice of action 327
3.7.5 Client appeal process 327

4.0 Policy/Procedures/Responsibilities for Services 327

4.1 Services 327
4.1.1 Service values 327
4.1.2 Included services 328
4.1.3 Service settings 328
4.2 Clinical time frame requirements 328
4.3 Documentation requirements 328

5.0 Information Systems Business Rules 328

5.1 Financial rules 328
5.1.1 Hospital contracts with state, not KCMHP 328
5.1.2 Hospital billing 328
5.1.3 Hospital submission of discharge information to KCMHP 328

(VIII. INPATIENT SERVICES LEVEL OF CARE, CONTINUED)

5.1.4 HOSPITAL SENDS INPATIENT CLIENT INFORMATION FORM TO KCMHP 329
5.1.5 KCMHP REVIEW OF DSHS HOSPITAL PAYMENTS 329
5.1.6 RECOUPMENT OF PAYMENT 329
5.1.7 OUT-OF-STATE HOSPITALS 329

6.0 LIST OF ATTACHMENTS 329

7.0 REFERENCES 330

ATTACHMENTS:

Which RSN Should a Hospital Call for Authorization ..... Attachment A
Daily Authorization Log ..... Attachment B
Notification of Medicare or Commercial Insurance ..... Attachment C
Change in Legal Status Form ..... Attachment D
Patient Placement Decision Tree: Adults ..... Attachment E
Patient Placement Decision Tree: Juveniles ..... Attachment F
Extension Request for Hospitalization Form ..... Attachment G
Inpatient Client Information Form ..... Attachment H
Notice of Action for Inpatient Services ..... Attachment I
Notice of Determination for Inpatient Services ..... Attachment J

IX. ADDITIONAL OUTPATIENT SERVICES 345

1.0 POLICY TITLE 345

2.0 PURPOSE 345

3.0 POLICY/PROCEDURES/RESPONSIBILITIES 345

3.1 CLUBHOUSE SERVICES 345
3.2 CRISIS DIVERSION FACILITY 346
3.3 CRISIS DIVERSION INTERIM SERVICES 346
3.4 CRISIS TEAM (MOBILE) 347
3.5 CRISIS RESPITE PROGRAM (CRP) AT DOWNTOWN EMERGENCY SERVICE CENTER (DESC) 347
3.6 EXPANDING COMMUNITY SERVICES (ECS)/COMMUNITY SUPPORT AND RECOVERY SERVICES 348
3.7 FORENSIC ASSERTIVE COMMUNITY TREATMENT (FACT) 348
3.8 FORENSIC INTENSIVE SUPPORTIVE HOUSING (FISH) 349
3.9 GERIATRIC REGIONAL ASSESSMENT TEAM (GRAT) 350
3.10 HOUSING ACCESS SERVICES PROGRAM (HASP) 350
3.11 HOMELESS OUTREACH STABILIZATION AND TRANSITION (HOST) 351
3.12 INTEGRATED DUAL DISORDERS TREATMENT (IDDT) 352
3.13 LIAISONS 353
3.13.1 ADULT CRIMINAL JUSTICE LIAISONS 353
3.13.2 CHILDREN'S CRIMINAL JUSTICE LIAISONS 353
3.13.3 ADULT INPATIENT AND RESIDENTIAL LIAISONS 354
3.14 MEDICAID PERSONAL CARE (MPC) 354
3.15 MENTAL HEALTH COURT 356
3.16 MENTALLY ILL OFFENDERS 357
3.16.1 FORENSIC INTEGRATED REENTRY SUPPORT & TREATMENT (FIRST) - FORMERLY MIO-CTP 357
3.16.2 OFFENDER REENTRY COMMUNITY SUPPORT PROGRAM (ORCSP) - FORMERLY CIAP & DMIO 358
3.17 PEER BRIDGER PROGRAM 358
3.18 REENTERING OFFENDERS REFERRAL SERVICE (RORS) - FORMERLY SMIO 360
3.19 PROJECT FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS (PATH) 360
3.20 PROGRAM OF ASSERTIVE COMMUNITY TREATMENT (PACT) 361
3.21 REENTRY CASE MANAGEMENT SERVICES AND HOMELESSNESS PREVENTION PROGRAM 362
3.22 SUPPORTED EMPLOYMENT 363
3.23 WRAPAROUND FOR CHILDREN, YOUTH, AND FAMILIES 364
3.24 TRANSITION SUPPORT PROGRAM (TSP) 364

(IX. ADDITIONAL OUTPATIENT SERVICES, CONTINUED)

4.0 LIST OF ATTACHMENTS 365

5.0 REFERENCES 366

ATTACHMENTS:

RORS Intake Appointment Form ..... *Attachment A*
RORS Disposition Form ..... *Attachment B*
PACT Eligibility Screening Form ..... *Attachment C*
MIDD Wraparound Form ..... *Attachment D*

X. QUALITY MANAGEMENT AND EXTRAORDINARY OCCURRENCES 379

1.0 POLICY TITLE 379

2.0 PURPOSE 379

3.0 POLICY/PROCEDURES/RESPONSIBILITIES 379

3.1 QUALITY MANAGEMENT 379
3.1.1 QUALITY MANAGEMENT PLANS 379
3.1.2 QUALITY MANAGEMENT ACTIVITIES 380
3.1.3 MINIMUM COMPLIANCE REQUIREMENTS AND GUIDELINES 381
3.1.4 ADDRESSING CLIENT NEEDS 382
3.1.5 PERFORMANCE AND OUTCOME MEASUREMENT 382
3.1.6 QUALITY REVIEW TEAM (QRT) 382
3.1.7 QUALITY COUNCIL 383
3.2 EXTRAORDINARY OCCURRENCES 383
3.2.1 DEFINITION 383
3.2.2 REPORTING TIME FRAMES 384
3.2.3 REPORTING 385
3.2.4 REVIEW 385
3.2.5 QUALITY REVIEW 386

4.0 LIST OF ATTACHMENTS 387

5.0 REFERENCES 387

ATTACHMENTS:

Guidelines for Treating Older Adults ..... *Attachment A*
Guidelines for Treating Patients with HIV/AIDS ..... *Attachment B*
Certification for Mental Health Professionals ..... *Attachment C*
Certification for Sexual Minority Mental Health Specialist ..... *Attachment D*
Diagnosis-Specific Guidelines ..... *Attachment E*
Additional Signs and Symptoms of Mental Health Disorders in Children and Youth ..... *Appendix 1*
Recommendations Regarding Medication Prescription and Monitoring for Children ..... *Appendix 2*
Psychiatric Consultation Guidelines ..... *Attachment F*
Wraparound Guidelines ..... *Attachment G*
Developmental Guidelines ..... *Attachment H*
Practice Protocols for Peer Support ..... *Attachment I*
Extraordinary Occurrence Report Form ..... *Attachment J*
Extraordinary Occurrence 30-Day Standard Review ..... *Attachment K*
Practice Protocols for Recovery and Resiliency-oriented Mental Health Services ..... *Attachment L*
Foundational Mental Health Recovery Competencies and Curricula ..... *Appendix 1*
King County Mental Health Recovery and Resiliency-oriented Clinical Skills Inventory ..... *Appendix 2*

XI. CREDENTIALING AND CONTRACT MONITORING 473

1.0 POLICY TITLE 473

2.0 PURPOSE 473

3.0 POLICY/PROCEDURES/RESPONSIBILITIES 473

3.1 POLICY 473
3.1.1 CREDENTIALING MINIMUM REQUIREMENTS 473
3.1.2 PROVIDER AND SUBCONTRACTOR CREDENTIALING/RE-CREDENTIALING 476
3.1.3 CREDENTIALING PROVIDER SUBCONTRACTORS 476
3.1.4 CONTRACT MONITORING AND MANAGEMENT 476
3.1.5 PROVIDER PROFILES 477
3.1.6 COMPLAINTS 477
3.2 PROCEDURES 477
3.2.1 PROVIDER AND SUBCONTRACTOR CREDENTIALING/RE-CREDENTIALING 477
3.2.2 PROVIDER TIME FRAME FOR COMPLETING CREDENTIALING FORMS 478
3.2.3 SITE VISIT REQUIREMENTS 478
3.2.4 KCMHP REVIEW OF APPLICATIONS 478
3.2.5 VERIFICATION WITH STATE 479
3.3 CREDENTIALING PROVIDER SUBCONTRACTORS 479
3.3.1 PROVIDERS MAY SUBCONTRACT UPON KCMHP APPROVAL 479
3.3.2 PROVIDERS SUBMIT DOCUMENTATION ON BEHALF OF SUBCONTRACTORS 479
3.3.3 TIME FRAME FOR APPROVING SUBCONTRACTORS' APPLICATIONS 479
3.3.4 PROVIDERS' RESPONSIBILITIES RELATED TO SUBCONTRACTORS 479
3.3.5 PROVIDER OFFICE CLOSURES 481
3.3.6 CONTRACT MONITORING COMPLIANCE REVIEW AND CLINICAL REVIEW 481
3.3.7 CONTRACT MONITORING AND MANAGEMENT 485
3.3.8 PROVIDER PROFILES 486
3.3.9 RESOLVING PROVIDER INQUIRIES AND COMPLAINTS 486

4.0 REFERENCES 486

XII. INFORMATION MANAGEMENT 489

1.0 POLICY TITLE 489

2.0 PURPOSE 489

3.0 POLICY/PROCEDURES/RESPONSIBILITIES 489

3.1 POLICY 489
3.1.1 CONFIGURATION OF THE MENTAL HEALTH INFORMATION SYSTEM 489
3.1.2 DATA PROVIDER 490
3.1.3 DATA PROVIDER REQUIREMENTS 490
3.1.4 DATA SECURITY 491
3.1.5 DATA COLLECTION 491
3.1.6 DATA REPORTING 492
3.1.7 DATA TIMELINESS 493
3.1.8 DATA COMPLETENESS 494
3.1.9 DATA ACCURACY 495
3.1.10 UNDUPLICATION OF CLIENT RECORDS 495
3.1.11 ONLINE INFORMATION 496
3.1.12 INFORMATION SYSTEM REVISIONS 496
3.1.13 DATA PRODUCTS 497
3.2 PROCEDURE: INFORMATION SYSTEMS BUSINESS RULES 498
3.2.1 DATA TESTS 498
3.2.2 CASE RATE VALIDATION 499
3.2.3 AUTHORIZATION STATUS CODES 500
3.2.4 NON-MEDICAID RESOURCE TEST 500
3.2.5 CANCELLATION OF WAITLIST OUTPATIENT AUTHORIZATION REQUESTS 501
3.2.6 NON-MEDICAID WAITLIST UPDATE 501
3.2.7 DETERMINATION OF RESIDENCY 502

(XII. INFORMATION MANAGEMENT, CONTINUED)

3.2.8 DETERMINING COVERAGE 502
3.2.9 PROVIDER OUTPATIENT AUTHORIZATION REQUESTS 503
3.2.10 KCMHP OUTPATIENT AUTHORIZATION FUNCTIONS 506
3.2.11 AUTHORIZATION RESPONSE RECORD 507
3.3 INFORMATION SYSTEM BUSINESS RULES 508
3.3.1 SERVICE PERIODS 508
3.3.2 CASE RATE BENEFIT CASE RATE CODE CALCULATION 508
3.3.3 MANAGEMENT OF NON-MEDICAID DOLLARS 509
3.4 RESPONSIBILITIES 510
3.4.1 KING COUNTY MHCADSD 510
3.4.2 PROVIDERS 510

4.0 LIST OF ATTACHMENTS 511

5.0 REFERENCES 511

ATTACHMENTS:

Data Dictionary Summary of Attributes ..... *Attachment A*
Data Dictionary Provider Transactions ..... *Attachment B*
MHCADSD and KCMHP Providers HIPAA Trading Partner Agreement ..... *Attachment C*
MHCADSD and KCMHP Providers' Trading Partner Agreement 837 Health Care Claim Professional Transaction ..... *Attachment D*
Service Encounter Reporting Instructions ..... *Attachment E*

XIII. PRIVACY AND SECURITY OF INFORMATION SYSTEMS DATA AND CLIENT RECORDS 787

1.0 POLICY TITLE 787

2.0 PURPOSE 787

3.0 POLICY/PROCEDURES/RESPONSIBILITIES 787

3.1 INFORMATION SECURITY AND PRIVACY POLICIES 787
3.2 ACCESS TO MHCADSD IS 787
3.3 DATA EXTRACTS 789
3.4 RELEASE OF CLIENT INFORMATION FROM MHCADSD IS 790
3.5 MEDICAL RECORDS 791
3.6 ELECTRONIC MESSAGE SYSTEMS 791
3.7 INTERNET ACCESS 792
3.8 COMPUTER VIRUSES 792
3.9 DATA SHARING AGREEMENTS 792

4.0 LIST OF ATTACHMENTS 792

5.0 REFERENCES 793

ATTACHMENTS:

Protection of Confidential Client Information ..... *Attachment A*
Designated Record Set ..... *Appendix 1*
Limited Data Set ..... *Appendix 2*
Consent/Authorization for Release Information ..... *Appendix 3*
Maximum Potential Access to and Use of PHI by MHCADSD Staff Without Client Authorization or Consent ..... *Appendix 4*
Routine Disclosure of PHI by MHCADSD Staff ..... *Appendix 5*
Redisclosure of Enrollment Information without Client Consent ..... *Appendix 6*
Request for Client Information without Authorization ..... *Appendix 7*
Form for Invalid Authorizations ..... *Appendix 8*
Request to Communicate by Alternate Means ..... *Appendix 9*
Log of Disclosures without Client Consent or Authorization ..... *Appendix 10*
Request to Revoke Consents for the Release of Information ..... *Appendix 11*
Request to Amend/Correct PHI ..... *Appendix 12*
Request to Restrict Access of PHI ..... *Appendix 13*

(XIII. PRIVACY AND SECURITY OF INFORMATION SYSTEMS, CONTINUED)

Request for Accounting of Disclosures.....*Appendix 14*
Oath of Confidentiality.....*Appendix 15*
Disclosure of Minimum Electronic MH PHI.....*Appendix 16*
Application for Access to Information System (Providers).....*Appendix 17A*
Application for Access to Information System (MHCADSD).....*Appendix 17B*
MHCADSD Procedure for Making a CD containing PHI.....*Appendix 18*
DSHS Oath of Confidentiality for PHI.....*Appendix 19*
Business Associate Agreement.....*Appendix 20*
Research and Evaluation Data Sharing Agreement.....*Appendix 21*
Data Security Requirements.....*Appendix 21-A*
Data Disposition Certification.....*Appendix 21-B*
Research and Evaluation Oath of Confidentiality.....*Appendix 21-C*
Data Use Agreement for Limited Data Set.....*Appendix 22*
PRISM Registration.....*Appendix 23*
Evaluation and Research Review Committee.....*Attachment B*

XIV. PROGRAM INTEGRITY.....913

1.0 POLICY TITLE.....913

2.0 PURPOSE.....913

3.0 POLICY/PROCEDURES/RESPONSIBILITIES: PROGRAM INTEGRITY.....913

3.1 PROHIBIT MEDICAID PAYMENTS TO EXCLUDED INDIVIDUALS AND ENTITIES.....913
3.2 MAINTAIN A PLAN TO LIMIT FRAUD, WASTE, AND ABUSE.....913

4.0 EXCLUDED PROVIDERS.....913

4.1 POLICY STATEMENT.....913
4.2 DEFINITIONS.....914
4.3 MONITORING.....914
4.4 REPORTING.....914
4.5 ENFORCEMENT.....915
4.6 PENALTIES.....915
4.7 TERMINATION.....915
4.8 LOCATION OF LIST OF EXCLUDED INDIVIDUALS.....915
4.9 LOCATION OF SSA SECTION 1128.....916

5.0 FRAUD, WASTE, AND ABUSE COMPLIANCE PLAN.....916

5.1 POLICY STATEMENT.....916
5.2 PURPOSE.....916
5.3 DEFINITIONS.....916
5.4 COMPLIANCE OFFICER AND COMMITTEE.....918
5.5 MONITORING.....919
5.6 PROVIDER RELATIONS AND CONTRACTS.....920
5.7 PROVIDER RESPONSIBILITIES.....921
5.8 EDUCATION AND TRAINING.....922
5.9 DEVELOPING EFFECTIVE LINES OF COMMUNICATION.....922
5.10 ENFORCEMENT THROUGH DISCIPLINARY MEASURES.....924

6.0 LIST OF ATTACHMENTS.....924

7.0 REFERENCES.....925

ATTACHMENTS:

CMS Letter - Excluded Providers 01-16-2009.....*Attachment A*
CMS Letter - Program Integrity 06-12-2008.....*Attachment B*
False Claims Act.....*Attachment C*
Administrative Remedies.....*Attachment D*
Provider Requirements.....*Attachment E*
Employee Education about False Claims Recovery.....*Attachment F*

XV. DEFINITIONS 957

ACTION 957
ADJUSTMENT 957
ADULT 957
ADULT CRISIS SERVICES 957
ADULT FAMILY HOME 957
ADVANCE DIRECTIVE 957
AGENCY 957
ALLIED SYSTEM PROVIDER 957
ALLIED SYSTEM 957
APPEAL 957
AUTHORIZATION 957
BOUNDARY SPANNER 958
BREACH 958
CARE COORDINATION 958
CARE PLAN 959
CASE MANAGEMENT 959
CASE MIX 959
CASE RATE 959
CATASTROPHIC AND PERMANENT 959
CHILD/ADOLESCENT 959
CHILD AND FAMILY TEAM 959
CHILDREN'S CRISIS OUTREACH RESPONSE SYSTEM (CCORS) 959
CHILDREN'S LONG-TERM INPATIENT PROGRAM (CLIP) 959
CHILDREN'S GLOBAL ASSESSMENT SCALE (CGAS) 959
CHRONICALLY HOMELESS 960
CHILDREN'S PROGRAM 960
CLIENT 960
CLIENT LOOKUP SYSTEM (CLS) 960
CLIENT SERVICES 960
CLINICAL REVIEW 960
COMMUNITY-BASED 960
COMPLAINT 960
COMMUNITY MENTAL HEALTH AGENCY (CMHA) 960
CONFIDENTIALITY 960
CONTINUED STAY CRITERIA 960
CO-OCCURRING DISORDER (COD) INTEGRATED TREATMENT SERVICES 960
COORDINATED SERVICES AND SUPPORTS 961
CORRECTIVE ACTION PLAN 961
CRISIS EVALUATION 961
CRISIS SERVICE 961
CRISIS STABLIZATION PLACEMENT 961
CULTURAL ASSESSMENT 961
CULTURAL COMPETENCE 961
CULTURAL DIFFERENTIAL 962
CULTURE 962
DEAF 962
DESIGNATED MENTAL HEALTH PROFESSIONAL (DMHP) 962
DIAGNOSTIC CLASSIFICATION: 0-3R (DC:0-3R) 962
DISAGREEMENT WITH TREATMENT PLAN 962
EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) 962
EMERGENT CARE 963
ENROLLEE 963
ETHNIC MINORITY 963
EVALUATION AND TREATMENT (E&T) FACILITY 963
EXTRAORDINARY TREATMENT PLAN (ETP) 963
FACILITATOR 963
FAIR HEARING 963
FAMILY 963

(XV. DEFINITIONS, CONTINUED)

FAMILY-CENTERED....963
FAMILY-CENTERED PRACTICES....963
FAMILY FRIENDLY....964
FAMILY INTEGRATED TRANSITIONS (FIT) PROGRAM....964
FAMILY PARTNERSHIP....964
FINANCIAL EXPLOITATION....964
FLAG....964
FORENSIC ASSERTIVE COMMUNITY TREATMENT (FACT)....964
FORENSIC INTEGRATED REENTRY SUPPORT AND TREATMENT (FIRST), FORMERLY MIO-CTP....965
FREQUENT USE....965
GERIATRIC REGIONAL ASSESSMENT TEAM (GRAT)....965
GLOBAL ASSESSMENT OF FUNCTIONING (GAF) SCALE....965
GRIEVANCE....965
GUIDELINES....965
HARD OF HEARING....965
HIGH UTILIZATION....965
HOMELESS....965
HOMELESS OUTREACH, STABILIZATION AND TRANSITION (HOST) PROJECT....965
HOSPITAL DIVERSION BEDS – ADULT....966
HOSPITAL DIVERSION BEDS – CHILDREN/YOUTH....966
INSTITUTION FOR MENTAL DISEASES (IMD)....966
INDIVIDUAL SERVICE PLAN (ISP)....966
INITIAL CRISIS OUTREACH....966
INPATIENT....966
INPATIENT DIVERSION BEDS (SEE HOSPITAL DIVERSION BEDS – ADULT)....966
INTAKE....966
INTEGRATED DUAL DISORDER TREATMENT (IDDT)....967
INVOLUNTARY TREATMENT/COMMITMENT....967
ITA DETAINED PERSON....967
KING COUNTY CARE PARTNERS....967
KCMHP CLIENT....967
KING COUNTY MENTAL HEALTH, CHEMICAL ABUSE & DEPENDENCY SERVICES DIVISION....967
LEVELS OF CARE....967
LONG-TERM REHABILITATION (LTR)....968
MANAGED CARE....968
MEDICAID ABUSE....968
MEDICAID ELIGIBILITY LOOKUP SYSTEM (MELS)....968
MEDICAID FRAUD....969
MEDICAID RECIPIENT....969
MEDICALLY NECESSARY/MEDICAL NECESSITY....969
MENTAL HEALTH CARE PROVIDER (MHCP)....969
MHCADSD INFORMATION SYSTEM (MHCADSD IS)....969
MENTAL HEALTH COURT....969
MENTAL HEALTH INFORMATION SYSTEM (MHIS)....970
MORAL RECONATION THERAPY (MRT)....970
MULTI-SYSTEM INVOLVED....970
MULTISYSTEMIC THERAPY (MST)....970
NATURAL SUPPORTS....970
NON-FACILITY-BASED MEDICALLY COMPROMISED HOMEBOUND CLIENT....970
NON-MEDICAID....971
NOTICE OF ACTION....971
NOTICE OF DETERMINATION....971
OLDER ADULT....971
OLDER ADULT CRISIS SERVICES....971
OMBUDS SERVICE....971
OUTCOME MEASURE(S)....971
OUTREACH....971
PARENT-INFANT RELATIONSHIP GLOBAL ASSESSMENT SCALE (PIR-GAS)....972

(XV. DEFINITIONS, CONTINUED)

PEER BRIDGER 972
PENETRATION RATE 972
PERFORMANCE INDICATOR(S) 972
PRE-ADMISSION SCREENING AND ANNUAL RESIDENTIAL REVIEW (PASARR) 972
PREPAID INPATIENT HEALTH PLAN (PIIHP) 972
PREVALENT LANGUAGES 972
PREVOCATIONAL SERVICES 972
PRIMARY CARE PROVIDER (PCP), PRIMARY CARE PROVIDER MENTAL HEALTH (PCPMH) 972
PROGRAM FOR ALL-INCLUSIVE CARE OF THE ELDERLY (PACE) 972
PROGRAM FOR ASSERTIVE COMMUNITY TREATMENT (PACT) 973
PROVIDER 973
PROVIDERONE 973
PROVIDER PROFILE 973
PSYCHOTHERAPY 973
QUALITY ASSURANCE (QA) 973
QUALITY IMPROVEMENT 973
QUALITY MANAGEMENT 973
QUALITY REVIEW TEAM (QRT) 973
RECOVERY 973
REGIONAL SUPPORT NETWORK (RSN) 974
RSN DEMOGRAPHIC SEARCH 974
RESILIENCY 974
ROUTINE CARE 974
ROUTINE SERVICES 974
SCREENING 974
SERVICE POPULATIONS 974
SERIOUSLY EMOTIONALLY DISTURBED (SED) 974
SEXUAL MINORITY 975
STANDARD SUPPORTIVE HOUSING (SSH) 975
STARS 975
SUPERVISED LIVING (SL) 975
SUPPORTED EMPLOYMENT (SE) 975
SYSTEM OF CARE 975
SYSTEM COLLABORATION 976
TERMINATION CRITERIA 976
TIER BENEFIT (SEE CASE RATE) 976
TRAUMA-INFORMED CARE (TIC) 976
TTY OR TDD 976
URGENT CARE 976
UTLIZATION REVIEW (UR) 976
VOCATIONAL SERVICES 976
WAIT LIST 976
WAIVER 976
WASTE 977
WELLNESS RECOVERY ACTION PLAN (WRAP) 977
WRAPAROUND 977
WRAPAROUND COLLABORATION 977
YOUTH 977

I. PURPOSE OF THE KING COUNTY REGIONAL SUPPORT NETWORK

1.0 POLICY TITLE: PURPOSE OF THE KING COUNTY REGIONAL SUPPORT NETWORK (KCRSN)

1.1 Originally Implemented: August 10, 1993

1.2 Reviewed and revised: November 2014

1.3 Officially Adopted: January 2, 2015

1.4 Effective Date: February 2, 2015

1.5 Signed: _____
Jean Robertson, Assistant Division Director/RSN Administrator

2.0 PURPOSE: To define the mission, goals, and values of the King County Regional Support Network (KCRSN).

2.1 Mission

2.1.1 The mission of the King County Regional Support Network (the RSN) is to provide quality, comprehensive, age and culturally competent inpatient and outpatient mental health care to persons with severe mental illness, including those with co-occurring disorders. The RSN is committed to providing a seamless, integrated system of services delivered from a recovery and trauma-informed orientation, which promotes resiliency through a comprehensive array of flexible services that will enable individuals to live, work, learn, and fully participate in our society.

2.2 Goal

2.2.1 The goal of the RSN, in partnership with the King County mental health community, is to carefully define the benefits and limits of the mental health system and provide the highest quality services and supports that promote mental health recovery and resiliency.

2.3 Guiding Principles

2.3.1 The RSN is committed to the development of an individually-driven, recovery-oriented, and trauma-informed system of care. The guiding principles of such a system are consistent with the Substance Abuse and Mental Health Services Administration's (SAMHSA) working definition of recovery:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Recovery:

A. Emerges from hope;

B. Is person-driven;

C. Occurs via many pathways;

D. Is holistic;

E. Is supported by peers and allies;

F. Is supported through relationship and social networks;

G. Is culturally-based and influenced;

H. Is supported by addressing trauma;

I. Involves individual, family and community strengths and responsibility; and

J. Is based on respect.

For additional detail: http://www.samhsa.gov/newsroom/advisories/1112223420.aspx

2.3.2 The RSN shall ensure that the service delivery system provides equitable access and competent care to the culturally and ethnically diverse residents of King County.

2.3.3 The RSN values the strengths and assets of clients, their families, and significant others, and shall seek to include their participation in decision-making, policy-setting, and the development of services and systems.

2.3.4 The RSN shall ensure clinical service quality that is based on scientific research, nationally recognized standards of care for specific mental illnesses, and is focused on recovery and resiliency.

2.3.5 The RSN shall work in partnership with allied system providers to deliver quality individualized services, supports and outcomes.

2.3.6 The RSN shall be accountable to the public, including individuals receiving care, to ensure that resources are carefully managed to provide the highest quality services to a clearly defined eligible population.

3.0 POLICY/PROCEDURES/RESPONSIBILITIES:

3.1 King County Regional Support Network (KCRSN)

3.1.1 A division of the Department of Community and Human Services, the RSN shall be responsible for policy direction and the financial management of the publicly funded mental health system in King County. The RSN shall oversee both the Regional Support Network and the King County Mental Health Plan (KCMHP) for King County under contract with the State of Washington Department of Social and Health Services.

3.2 Systems Coordination

3.2.1 The RSN shall work in active partnership with allied system providers to ensure that clients receive a balanced, coordinated, and individualized array of quality supports and services.

3.2.2 The RSN shall have responsibility for developing formal working agreements with the allied system providers when needed or required. The agreements shall specify roles and responsibilities of all parties toward coordination of care for mutually served populations.

A. Working agreements shall reflect an active partnership between the RSN and other system providers through:

1. Assurance of an overlapping community and institutional network of care for people served by multiple systems;

2. Participation in the development of respective individual service plans as they pertain to and affect clients of the RSN;

3. Exchanging data and information; and

4. Collaboration in monitoring and quality assurance activities related to the development and maintenance of an integrated system of care that seeks to involve clients, prevent inappropriate hospitalization or incarceration, provide cross-system individualized support, and share costs of care.

B. The agreements shall be systematically and regularly evaluated for application and effectiveness through system surveys, entity contract monitoring, and individual service plan reviews.

3.2.3 Providers shall be responsible for developing protocols for collaborative relationships with other systems through which services are being planned for mutually served clients. Protocols shall document:

A. Roles and responsibilities for coordination of care for mutually served clients; and

B. How to access services and the mechanisms for joint planning for individualized services and information-sharing procedures within confidentiality requirements.

3.3 The RSN will provide and promote community and provider education to increase awareness of how individuals recover from mental illness and develop resiliency, as well as improve social inclusivity, thereby diminishing the stigma associated with mental illness.

3.4 The RSN will seek and include input about service needs and priorities. This will be accomplished through:

3.4.1 Publicized forums including an annual Legislative Forum and forums identified and organized by the Quality Council of the RSN.

3.4.2 Informing community stakeholders of opportunities to provide input. Community stakeholders include clients, family members, advocates, culturally diverse communities including clients who have limited English proficiency, service providers, social service agencies, organizations representing persons with disabilities, tribal authorities, and groups that are underserved.

3.4.3 Including stakeholders in planning groups and in regularly scheduled and ad hoc meetings of the RSN.

4.0 REFERENCES:

Washington State Law, Regulations, and Policy including any successor, amended, or replacement laws, regulations**,** or policies

- Chapters 388-865, 388-877, and 388-877A Washington Administrative Code – Department of Social and Health Services – Mental Health – Community Mental Health and Involuntary Treatment Programs

King County Law, Regulations, and Policy including any successor, amended, or replacement laws, regulations**,** or policies

- King County Vision and Values 1993
- King County Ordinance 15327 – Adopting the concept of recovery as the Policy framework for the publicly funded mental health system in King County

Other

- The Department of Social and Health Services (DSHS) State Mental Health Contract and any subsequent amendments.
- The Department of Social and Health Services (DSHS) PIHP Contract and any subsequent amendments.
- Substance Abuse and Mental Health Services Administration (SAMHSA) Consensus Statement on Mental Health Recovery
- Substance Abuse and Mental Health Services Administration (SAMHSA) National Center for Trauma-Informed Care: What is Trauma-Informed Care?

II. PURPOSE OF THE KING COUNTY MENTAL HEALTH PLAN

1.0 POLICY TITLE: PURPOSE OF THE KING COUNTY MENTAL HEALTH PLAN (KCMHP)

1.1 Originally Implemented: April 1, 1995

1.2 Reviewed and revised: November 2014

1.3 Officially Adopted: January 2, 2015

1.4 Effective Date: February 2, 2015

1.5 Signed: _____
Jean Robertson, Assistant Division Director/RSN Administrator

2.0 PURPOSE: To define the purpose and goals of the King County Mental Health Plan (KCMHP) and the population to be served.

2.1 Purpose

2.1.1 To provide community-based outpatient mental health services, delivered with a recovery and trauma-informed orientation designed to promote resiliency, to Medicaid recipients in King County and, as resources permit, a portion of the King County resident non-Medicaid population.

2.1.2 To provide crisis services to all persons in King County who present with a crisis where a mental illness or psychiatric diagnosis may be present.

2.1.3 To provide mental health residential treatment services to eligible adults in King County, as resources permit.

2.1.4 To authorize voluntary psychiatric hospital admissions for eligible persons at local community hospitals and to review and authorize length-of-stay extensions.

2.1.5 To authorize involuntary psychiatric hospital admissions for eligible persons at local community hospitals, evaluation and treatment facilities, and state hospitals, and to review and authorize length-of-stay extensions.

2.1.6 To ensure that a recovery and trauma-informed model that promotes resiliency is the policy framework for developing and operating the mental health services for which King County is responsible.

A. Services provided shall acknowledge the unique needs of the diverse cultural and ethnic groups represented in the King County community and recognize the impact of language on the delivery and acceptance of culturally relevant services.

B. Services shall be developmentally and age appropriate and support recovery and resiliency for all age groups served by the KCMHP.

2.2 Goals

2.2.1 Through a choice of providers within a provider network, the KCMHP shall provide access to care, appropriate levels of care, and services that are age-appropriate and culturally relevant.

2.2.2 The KCMHP shall provide timely access to inpatient management functions.

2.3 Service Populations

2.3.1 The populations to be served are children, adults, and older adults (see Definitions). See Sections V, VI, VII, VIII, and IX of this manual for specific eligibility criteria.

2.3.2 The KCMHP shall, in the development and provision of services, recognize the unique social and legal status of Indian nations and tribes under the Supremacy clause and the Indian Commerce clause of the United States Constitution, federal treaties, and other statutes.

A. American Indians (as defined by 25 United States Code 1603) may dis-enroll from the state-managed care plan and receive mental health services by Indian health service programs or tribal clinics.

B. Tribal members may enroll or dis-enroll monthly from the state-managed care plan.

3.0 POLICY/PROCEDURES/RESPONSIBILITIES:

3.1 The Regional Support Network (RSN)

The RSN is responsible for the design, management, implementation, and operation of the KCMHP under its contractual agreements with the State of Washington. The RSN shall make policy decisions governing the KCMHP.

3.2 King County Mental Health Plan (KCMHP)

The services and activities of the KCMHP shall be administered through a partnership of the RSN, a contracted community mental health provider network, and allied systems.

3.3 Providers

3.3.1 Licensed community mental health centers and specialized service agencies shall provide direct services to clients under provider agreements and contracts managed by the RSN.

3.3.2 Providers shall maintain documentation that supports implementation of the requirements of the King County Mental Health Plan Policies and Procedures (P&P).

4.0 REFERENCES:

Washington State Law, Regulations, and Policy including any successor, amended, or replacement laws**,** regulations**,** or policies

- Chapters 388-865, 388-877, and 388-877A Washington Administrative Code – Department of Social and Health Services – Mental Health – Community Mental Health and Involuntary Treatment Programs
- Federal 1915(b) Waiver Renewal
- King County Ordinance 15327 of 2005

Other

- The Department of Social and Health Services (DSHS) State Mental Health Contract and any subsequent amendments.
- The Department of Social and Health Services (DSHS) PIHP Contract and any subsequent amendments.

III. CLIENT RIGHTS

1.0 POLICY TITLE: CLIENT RIGHTS

1.1 Originally Implemented: April 1, 1995

1.2 Reviewed and revised: November 2014

1.3 Officially Adopted: January 2, 2015

1.4 Effective Date: February 2, 2015

1.5 Signed: _____
Jean Robertson, Assistant Division Director/RSN Administrator

2.0 PURPOSE: To ensure clients of the King County Mental Health Plan (KCMHP):

2.1 Are fully informed about available services;

2.2 Are made aware of their rights and that these rights are protected;

2.3 Are provided an opportunity to complete or modify an advance directive at any time;

2.4 Can access information, referral, and advocacy services from KCMHP Client Services;

2.5 Can access assistance from an independent Ombuds service;

2.6 Can file an informal complaint and receive assistance during the resolution process;

2.7 Can file a grievance and receive assistance during the resolution process;

2.8 Are notified of any determinations or adverse actions by the KCMHP; and

2.9 Can file an appeal in the event of an adverse action and receive assistance during the resolution process.

3.0 POLICY/PROCEDURES/RESPONSIBILTIES: INFORMATION REQUIREMENTS

3.1 At the time of an intake evaluation:

3.1.1 Medicaid clients shall be offered the Benefits Booklet for People Enrolled in Medicaid published by the state Department of Social and Health Services (DSHS) at intake and informed the booklet is also available on the DSHS website at http://dshs.wa.gov/dbhr/mhmedicaidbenefit.shtml; and

3.1.2 All clients shall be offered access to and, at the client's request, provided a copy of the:

A. King County Regional Support Network (KCRSN) Brochure, Public Mental Health Services in King County; and

B. KCRSN Practice Guidelines.

3.2 Clients must be able to understand the information provided to them, including clients with communication barriers or sensory impairments. This shall include providing:

3.2.1 Information in a client's primary language, when interpretation is needed for adequate understanding between the client and the provider or KCMHP for interactions including but not limited to:

A. Customer service;

B. All appointments for any covered service;

C. Crisis services; and

D. All steps necessary to file a grievance or appeal;

3.2.2 Access free of charge for clients to:

A. Interpreters who are:

1. Qualified and objective, and

2. Not family members or friends;

B. Persons who are proficient in the use of Text Telephone (TTY)/Telecommunication Device for the Deaf (TDD) or alternate communication devices or languages (e.g., American Sign Language) to serve persons who are deaf or hard of hearing;

3.2.3 Information in language that is appropriate for the client's level of education (for written documents, no more than a fourth-grade reading level whenever possible).

Notification to clients that written information in alternative formats, such as audiotape, Braille, or large print, is available and may be accessed upon request. Audio versions of the KCRSN brochure and client rights are available on compact disk (CD) from KCMHP Client Services and at the KCMHP website at: http://www.kingcounty.gov/healthServices/MentalHealth/Plans/brochure.aspx;

3.2.4 Written translations in:

A. Spanish: for generally available materials including, at minimum:

1. Applications for services;

2. Consent forms; and

3. Notices of Determination;

B. Prevalent languages established by DSHS (see Definitions) for the following materials:

1. Benefits Booklet for People Enrolled in Medicaid (available at the DSHS website: http://www.dshs.wa.gov/dbhr/mhmedicaid benefit.shtml);

2. KCRSN Brochure (available at the KCMHP website: http://www.kingcounty.gov/healthServices/MentalHealth/Plans/brochure.aspx);

3. Notice of Privacy Practices (available at the KCMHP website: http://www.kingcounty.gov/healthservices/MentalHealth/HIPAAPrivacyPractice.aspx);

4. Client rights (available at the KCMHP website: http://www.kingcounty.gov/healthServices/MentalHealth/Plans/brochure.aspx); and

5. Notices of Determination and Notices of Action distributed by the KCMHP;

3.2.5 Materials in English if the client's primary language is other than English but the client can understand English and is willing to receive the materials in English. The client's consent to receiving information and materials in English must be documented in the client record;

3.2.6 Information through alternate methods, the provision of which must be documented in the client record:

A. Audio or video recording in the client's primary language;

B. Having an interpreter read the materials in the client's primary language; or

C. Materials in an alternative format that is acceptable to the client; and

3.2.7 KCMHP and providers shall maintain a log of all client requests for interpreter services or translated written material.

3.3 If a client is unable to understand the information provided due to incapacity, the information will be provided to the client's family and/or representative, if available, or reoffered to the client when capacity is regained, should that occur.

3.4 A multilingual notice in each of the DSHS prevalent languages shall be posted that advises clients that information is available in other languages and how to access this information.

4.0 CLIENT RIGHTS:

4.1 Each client shall be informed of his or her rights under relevant state and federal regulations.

4.2 All client rights regarding protected health information shall be honored and the privacy of such information shall be maintained as described in Section XIII. Privacy and Security of Information Systems Data and Client Records.

4.3 Client rights shall be posted at facility locations where clients will most likely be able to view them. Rights shall be posted in each of the DSHS prevalent languages, copies of which may be accessed from the KCMHP website at: http://www.kingcounty.gov/healthServices/MentalHealth/Plans/brochure.aspx.

4.4 Clients shall be informed of their rights:

4.4.1 According to applicable sections of Chapters 388-877 and 388-877A Washington Administrative Code (WAC) or their successors, as described in the following table (see Attachment A for outpatient services rights);

4.4.2 By the provider by giving clients a copy of their rights and having those rights explained within 15 days of their initiation of outpatient or residential services; and

4.4.3 By KCMHP by sending clients a copy of the Rights for Client Receiving Outpatient Services (Attachment A) with the Notice of Determination for Authorization of Services (Attachment C):

A. When services are initially authorized; and

B. Annually when authorized to have services continued.

Client Rights Requirements				
Outpatient Services and Additional Outpatient Services (See Attachment A)	Residential Services	Outpatient Evaluation and Treatment Services	Inpatient Services	
			Voluntary	Involuntary
-0255, Consumer grievance process	-0235, Residential and housing services	WAC 388-877A-0195 (4) or its successor, Rights of consumers on a less restrictive court order	-0255, Consumer grievance process	-0255, Consumer grievance process
-0345, Choice of primary care provider	For licensed Boarding Homes and Adult Family Homes: Long-term care rights in accordance with Chapter 70.129 Revised Code of Washington (RCW) or its successor		-0561, Posting of consumer rights	-0561, Posting of consumer rights

Client Rights Requirements				
Outpatient Services and Additional Outpatient Services (See Attachment A)	Residential Services	Outpatient Evaluation and Treatment Services	Inpatient Services	
			Voluntary	Involuntary
-0355, Consumer request for a second opinion	For licensed Residential Treatment Facilities: Resident rights in accordance with WAC 246-337-075 or its successor			-0566, Rights of consumers receiving involuntary inpatient services
WAC 388-877-0600 or its successor, Individual rights				-0570, Rights related to antipsychotic medications
For Medicaid clients, inform them of their rights as found in the Benefits Booklet for People Enrolled in Medicaid published by the state Department of Social and Health Services				-0585, Petition for the right to possess a firearm

4.5 The understanding of rights must be documented in the clinical record by client signature.

4.6 If information is provided to the client (verbally or in writing) and the client expresses dissatisfaction about the matter presented, or may reasonably be expected to express dissatisfaction, the provider or KCMHP shall inform the client of complaint, grievance, and fair hearing options.

4.7 Client rights shall be protected to the extent possible. Providers shall educate staff on how to promote and protect client rights (Attachment A-1).

4.8 Each client is free to exercise his or her rights, and a client's exercising of any right shall not adversely affect the way the KCMHP, Ombuds service, provider agency, or any individual employee of the provider treats the client.

4.9 Written information shall be given to all adult and emancipated minor clients regarding their rights to make a mental health advance directive.

4.10 Each client shall be given a KCMHP HIPAA Notice of Privacy Practices.

4.11 Client Choice of Providers

4.11.1 A client may change his/her outpatient provider agency on request:

A. In the first 90 days of a first benefit;

B. Once during each subsequent 12-month period; or

C. More frequently at the client's request with documented justification and approval by KCMHP.

4.11.2 If a benefit is being terminated because a client is transferring to a new provider, the original provider must continue to provide services for the client until it receives an electronic notification of the termination of the benefit. The original provider shall not initiate termination of the benefit.

4.11.3 A client shall be offered, by the provider, a choice of mental health care providers (MHCPs) (the assigned provider staff person, who may be called a care coordinator, case manager, therapist, or other title) from within available staff of the provider. If the client does not make a choice, an MHCP shall be assigned to the client within 14 days following the request for mental health services.

4.11.4 A client may change MHCPs within the available staff of the same provider on request:

A. In the first 90 days of a first benefit;

B. Once during each subsequent 12-month period; or

C. More frequently with documented justification provided by the client.

4.11.5 When the client changes MHCPs within the staff of the same provider, the existing authorization continues.

4.12 Written or oral notification shall be provided no later than 15 working days after termination of a MHCP to clients currently open for services who have received a service from that MHCP in the previous 60 days. Notification must be documented in the client's clinical record.

4.13 Providers shall provide to a client upon a client's request:

4.13.1 Identification of individual MHCPs who are not accepting new clients;

4.13.2 Agency licensure, certification, and accreditation status; and

4.13.3 Information that includes but is not limited to education, licensure, registration, and board certification and/or re-certification of mental health professionals and MHCPs.

4.14 Persons seeking outpatient services who have a Washington Apple Health plan:

4.14.1 Shall be informed that they:

A. Are able to receive mental health services through their Washington Apple Health plan, when it has been determined that they have a mental illness that is not covered by the Access to Care criteria; and

B. Shall receive assistance in contacting their primary care provider if they will be seeking services through their Washington Apple Health plan;

4.14.2 May not be referred to their Washington Apple Health plan if they meet Access to Care criteria and are eligible for services from the KCMHP.

4.15 Informed consent shall be obtained for treatment to be provided.

4.15.1 During the process of obtaining informed consent, a client shall receive information regarding:

A. The client's health status;

B. Other commonly available treatment options, whether or not they are available from the provider, including alternatives (e.g., Dialectical Behavior Therapy, Transcranial Magnetic Stimulation) or other treatment that may be self-administered (e.g., Alcoholics Anonymous, self-help, and/or support groups);

C. Information to assist the client in choosing among relevant treatment options, including the risks, benefits, and consequences of treatment and non-treatment, and

D. The client's right to participate in decisions regarding his/her health care, including the right to refuse treatment and to express preferences about future treatment decisions.

4.15.2 No mental health professional, including MHCPs, acting within the lawful scope of mental health practice, shall be prohibited or restricted from advising or advocating on behalf of a client with respect to any of the above client rights.

4.16 Client Second Opinion

4.16.1 A client has the right to a second opinion provided by a mental health professional within a KCMHP agency.

4.16.2 Such opinions may be requested to address one or more of the following concerns:

A. The client believes he/she meets Access to Care criteria, despite a provider determination to the contrary;

B. The client needs additional information about the need for the services recommended by his /her treatment team and would like this information to come from another source; and

C. The client believes medically necessary, covered services are not being provided.

4.16.3 Providers shall develop policies and procedures for providing requested second opinions.

4.16.4 Providers may request that the second opinion be arranged with another provider agency within the KCMHP. Such a request should be made in writing to Client Services and be accompanied by an explanation describing why the opinion cannot be provided at the client's current agency.

4.16.5 When a provider mental health professional within the KCMHP is not available to provide a second opinion, the KCMHP will arrange at no cost to the client for an opinion from a provider agency currently contracted with another RSN to provide mental health services to clients.

4.16.6 In all cases, the second opinion must occur within 30 days of the client's request, unless the client requests a delay.

4.17 Seclusion and Restraint

4.17.1 A client has the right to be free of all forms of seclusion and physical and chemical restraint.

4.17.2 Seclusion and restraint shall not be used as a means of coercion, discipline, convenience, or retaliation.

4.17.3 Seclusion and restraint may only be used for the purpose of protecting the client or others and only if less restrictive de-escalation interventions have been determined to be ineffective. If seclusion and restraint are used, the duration shall be as brief as possible.

4.17.4 Seclusion and restraint may only be used in accordance with:

A. WAC 388-865-0545 and WAC 388-865-0546 or their successors if licensed and certified to provide evaluation and treatment facility services;

B. WAC 246-337-110 or its successor if licensed as a residential treatment facility;

C. WAC 388-97-075 or its successor if licensed and certified as a skilled nursing facility; and

D. WAC 388-76-10650 thru 388-76-10665 or their successors if licensed as an adult family home.

5.0 ADVANCE DIRECTIVES:

5.1 KCMHP and its providers shall respect and utilize advance directives for adults who have completed a mental health or physical health care advance directive in the provision of mental health services.

5.1.1 Providers shall ask all adults age 18 and over if they have a mental health or a physical health care advance directive at the time of intake.

5.1.2 A client's clinical record shall contain prominent documentation on ***whether or not*** the client has executed a mental health or physical health care advance directive, or if the client prefers not to disclose that information.

5.1.3 If a client at the time of intake is unable to articulate whether or not he or she has completed an advance directive, the provider shall make an inquiry about advance directives as soon as the person is able to provide a response. The information shall be documented in the client's clinical record.

5.1.4 If a client indicates he or she has a mental health advance directive or a physical health care advance directive, a copy shall be requested for the clinical record. A client's refusal to provide a copy shall be documented in the clinical record.

5.2 Providers shall implement written policies and procedures that ensure the provider complies with state and federal law on advance directives, including 42 Code of Federal Regulations (CFR) 438 and Chapter 71.32 RCW or their successors (Attachment A-2).

5.3 Each provider shall educate its staff on its advance directive policy and procedures (Attachment A-2).

5.4 Mental Health Advance Directives

5.4.1 Providers shall give each adult and emancipated minor client at time of intake written information on mental health advance directives which includes at a minimum a brief description of state law and information on how to execute a mental health advance directive.

5.4.2 Information provided to clients shall reflect changes in state law no later than 90 days after the effective date of the change.

5.4.3 If a client is unable to understand the information provided, due to incapacity, the information shall be provided to the client's family and/or representative, if available, or reoffered to the client when capacity is regained, should that occur.

5.5 A client's crisis plan shall also contain documentation on whether or not the client has executed a mental health or physical health care advance directive.

5.5.1 A client who has a mental health advance directive shall have a crisis plan.

5.5.2 The crisis plan shall be made available (by the provider) 24 hours a day. In particular, crisis plans shall be made available to a hospital mental health professional or Designated Mental Health Professional (DMHP) who is evaluating a client for need for admission as a means of ensuring the availability of the advance directive.

5.6 Providers shall ensure clients have a voice in developing advance directives.

5.7 No provider may limit the implementation of an advance directive because of a conscientious objection by the agency or an individual employee or subcontractor of the provider. Implementation may be limited only as allowed in RCW 71.32.150 or its successor.

5.8 A client may express dissatisfaction about noncompliance with an advance directive to KCMHP, either as an informal complaint or a formal grievance.

5.9 A client may also complain about noncompliance with an advance directive to the Department of Health at 1-360-236-2620, by email at HSQAComplaintIntake@doh.wa.gov, or online at www.doh.wa.gov.

5.10 Neither KCMHP nor a provider may condition the provision of care or otherwise discriminate against a client based on whether or not he/she has executed an advance directive.

6.0 CLIENT SERVICES:

6.1 Clients and family members shall be able to access KCMHP Client Services staff by phone or in person during regular business hours to obtain information on:

6.1.1 Client rights;

6.1.2 KCMHP services;

6.1.3 Referrals to care;

6.1.4 Benefits, eligibility, and access to care; and

6.1.5 Client options for advocacy in complaint, grievance, appeal, and fair hearing procedures.

6.2 Client Services staff shall be directly available to any caller through the KCMHP "800" number. Calls shall be answered during business hours, 8 a.m. to 5 p.m., Monday through Friday. Messages left on voicemail shall be answered within one business day.

6.2.1 An interpreter shall be provided for callers needing that service.

6.2.2 Callers using a TTY/TDD shall have access to a TTY/TDD at the time of the call.

6.3 Referrals shall be made as appropriate for Medicaid and non-Medicaid clients.

6.4 For complaints, grievances, appeals, and fair hearings Client Services shall:

6.4.1 Provide clients any reasonable assistance in completing forms and taking any other procedural steps, including but not limited to, referral to Ombuds services, interpreter services, and toll-free numbers with TTY/TDD and interpreter capability;

6.4.2 Assist a client and his/her representative, at any time before or during a grievance or appeal, in examining any documents in the possession of KCMHP that may be considered in the grievance or appeal determination; and

6.4.3 When the client has not already received the KCMHP Notice of Privacy Practices, send it to the client when grievance documentation requires the collection of protected health information.

6.5 Client Services shall document, log, and monitor for trends, all contacts, verbal or written referrals, and/or grievances to improve access to and quality of services.

7.0 OMBUDS SERVICES:

7.1 KCMHP will provide an Ombuds service that shall:

7.1.1 Assist and advocate for clients having complaints or grievances on any issues of concern to clients related to their mental health services, including access to such services;

7.1.2 Function independently of service provision and the KCMHP;

7.1.3 Be accessible to clients, including a toll-free, independent telephone line;

7.1.4 Receive and investigate complaints or grievances from clients, family members and other interested parties and assist in their resolution at the lowest possible administrative level;

7.1.5 Assist clients and family members in both informal resolution of complaints and through formal grievance, appeal, or fair hearing processes;

7.1.6 Involve other persons in the process at the client's request; and

7.1.7 Maintain confidentiality of client information.

7.2 Complaints, grievances, and fair hearings received by Ombuds staff will be tracked, analyzed, and reported to KCMHP to promote quality improvement.

7.3 KCMHP and providers shall coordinate with the Ombuds staff and refer clients, as appropriate, to Ombuds services.

7.4 Providers shall display brochures for the Ombuds service in a location that is readily accessible to clients.

7.5 Providers shall facilitate access for Ombuds service including and not limited to access to its physical property and access to provider records with client consent.

8.0 CLIENT COMPLAINTS:

8.1 Complaints about Mental Health Services

8.1.1 Definition: Any client expression of dissatisfaction that is resolved to the client's satisfaction through simple, first level dialog.

A term no longer used by the Division of Behavioral Health and Recovery for "reporting" in the formal grievance system.

8.1.2 Clients may complain about any issue of concern related to their mental health services, including access to such services. The term may also be used to refer to concerns that the provider, Ombuds service, or KCMHP investigates that fall outside the grievance system, such as concerns of a parent of an adult child, community members, or other system issues.

8.1.3 A client may communicate a complaint to:

A. His/her provider;

B. The Ombuds service; and/or

C. Client Services.

8.1.4 A client may request assistance in making a complaint from his/her provider, the Ombuds service, Client Services, or any other person of his/her choice.

8.1.5 Providers, the Ombuds service, and Client Services shall:

A. Attempt to informally resolve complaints and problems experienced by clients in KCMHP through simple, first level dialog and, when necessary, work together to do so;

B. Attempt to resolve complaints internally and quickly whenever possible. If a complaint cannot be resolved within 10 business days, the client shall be offered an opportunity to continue the complaint process or file a formal grievance;

C. Ensure both clients receiving services and clients applying for services may access the provider complaint process;

D. Monitor for retaliation and implement steps to prevent it;

E. Communicate resolution of the complaint to the client in a timely manner; and

F. Keep confidential all complaints at both the KCMHP and provider levels with documentation of these events filed separately from the client's clinical record.

8.1.6 Upon request, clients shall receive, at minimal cost, any written information that they and/or their representatives (including Ombuds services) may require for resolving complaints.

A. To ensure reasonable customer access, KCMHP, providers or subcontractors shall charge no more than 15 cents a page.

B. Reimbursement of costs, such as for staff time in preparation or supervision of the record review, are prohibited.

8.1.7 Providers, the Ombuds service, and KCMHP will keep records on client complaints, any steps taken to resolve complaints, and final resolutions. Records shall be kept for at least six years.

8.1.8 Providers shall develop and document mental health complaint procedures that comply with the requirements listed above.

8.2 Discrimination

8.2.1 Discrimination against clients and their families and significant others, due to gender, race, religion, color, national origin, Vietnam-era or other veteran status, sexual orientation, age, marital status, ancestry, political ideology, use of guide or service animals, use of Section 8 rent certificate, parental status, or creed is forbidden when prohibited by law.

8.2.2 Employees, clients, their families, and significant others shall be informed of complaint filing options for complaints related to the following human rights issues: gender, race, religion, color, national origin, Vietnam-era or other veteran status, sexual orientation, age, marital status, ancestry, political ideology, use of guide or service animals, use of Section 8 rent certificate, parental status, or creed.

8.2.3 Employees, clients, and their families and significant others shall be informed:

A. Where to file an external discrimination complaint;

B. Timelines for filing; and

C. That retaliation for filing is against the law and will not be tolerated.

8.2.4 Discrimination complaint information shall be easily available in public use or common areas.

8.2.5 Discrimination complaints may be referred to an outside agency for review.

9.0 THE GRIEVANCE SYSTEM (GRIEVANCES AND APPEALS):

9.1 The grievance system is the system that includes grievances and appeals handled at the provider, the KCMHP, and/or the state fair hearing levels. This system shall conform to the state DSHS grievance system templates; one for RSN (state-funded) services and one for Prepaid Inpatient Health Plan (PIHP) (Medicaid-funded) services. (Attachment B-1: Grievance System for PIHP and RSN).

9.2 KCMHP shall provide each contracted provider with the state DSHS-approved description of the grievance system (see Attachment B-1).

9.3 If the client is:

9.3.1 Currently receiving services, they shall be continued during a grievance, appeal, or state fair hearing process (including provider, KCMHP, and state fair hearing levels), at the client's request, within the limits described below; and

9.3.2 No longer receiving services, the grievance, appeal, and fair hearing process shall be continued until resolved, despite the fact that services are not ongoing.

9.4 Providers and KCMHP shall:

9.4.1 Maintain confidentiality of all grievances, appeals, and state fair hearings;

9.4.2 Keep documentation of grievances, appeals, and state fair hearings filed separately from the client's clinical record;

9.4.3 Participate as required in grievance, appeal, or state fair hearings procedures; and

9.4.4 Implement any corrective actions or other requirements that come out of grievance, appeal, or state fair hearing decisions.

9.5 A client may request assistance in filing a grievance, submitting an appeal, or requesting a state fair hearing from his/her provider, the Ombuds service, Client Services, or any other person of his/her choice. A provider assisting a client with a grievance or an appeal shall first obtain the client's written consent to do so.

9.6 A client shall be provided access to oral or manual interpreter services or toll-free numbers with adequate TTY/TDD and interpreter capability when pursuing a grievance, appeal, or state fair hearing.

9.7 Upon request, clients shall receive, at minimal cost, any written information that they and/or their representatives (including Ombuds services) may require for filing or resolving grievances, appeals, or fair hearings.

9.7.1 To ensure reasonable customer access, KCMHP, providers or subcontractors shall charge no more than 15 cents a page.

9.7.2 Reimbursement of costs, such as for staff time in preparation or supervision of the record review, are prohibited.

10.0 GRIEVANCES:

10.1 Definition: A grievance is:

10.1.1 An expression of dissatisfaction about RSN-related services other than an Action (see below) that is not resolved to the client's satisfaction through simple, first level dialog.

10.1.2 Grievances are formal processes that include requirements for letters of acknowledgement and resolution, as well as procedures for expediting grievances.

10.1.3 Possible subjects for grievances include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the mental health client's rights.

10.2 If the client so chooses he or she may receive assistance with the grievance process from:

10.2.1 A provider who is acting on the client's behalf;

10.2.2 The Ombuds office by contacting directly or through referral from a provider;

10.2.3 Client Services by contacting directly or through referral from a provider; and/or

10.2.4 Any other individual of his/her choosing.

10.3 The steps in a grievance

10.3.1 The client files a grievance with either his/her provider or with the KCMHP.

10.3.2 The grievance may be filed either by phone or in writing. The following information regarding the grievance should be collected:

A. Client's name;

B. How best to contact him/her;

C. Nature of the grievance, the word "grievance;"

D. Requested resolution to the grievance; and

E. If provided in writing, the statement shall be signed by the client (or parent or guardian).

10.3.3 The date of receipt of a grievance is the first business day on which a verbal or written grievance is received by either the KCMHP Client Services or the provider. If a phone message or letter initiating a grievance arrives on a non-business day, the date of receipt is the next business day.

10.3.4 Acknowledgement of receipt of the grievance

A. Within one business day of the receipt of the grievance:

1. If the client filed the grievance verbally, he/she shall be both phoned and mailed a letter verifying that the grievance has been received, noting the date of receipt, and informed he/she must also submit a written statement of the grievance; and

2. If the client filed the grievance in writing, he/she shall be mailed a letter verifying that the grievance has been received, noting the date of receipt.

B. The written acknowledgement shall include:

1. The date of receipt of the grievance;

2. A description of the grievance process, including timelines and opportunities for client input; and

3. A description of the client's right to continue services through the grievance process (including provider and KCMHP levels), at the client's request if the client is currently receiving services, within certain limits (see below).

10.3.5 Communicating about receipt of the grievance and reviewing the grievance

A. If the grievance is filed with a provider, the provider shall inform KCMHP Client Services in writing within one business day that the grievance has been received with the date of its receipt.

B. If the grievance is filed about a provider with KCMHP Client Services, KCMHP shall immediately inform the provider in writing of same.

C. All grievances, whether first filed with the provider or first with the KCMHP, are reviewed by the provider agency involved in the grievance.

D. If there is not an involved provider, the grievance will be reviewed by KCMHP (see below).

10.3.6 The provider or KCMHP staff reviewing the grievance must be:

A. A person(s) not previously involved with the issue of concern in the grievance, and

B. A mental health professional(s) if the grievance involves treatment issues or the denial of an expedited resolution of an appeal.

10.3.7 The provider shall offer the client and/or his/her representative an opportunity to review any clinical records relevant to the grievance and to submit oral or written information about the grievance prior to the provider decision on the grievance.

10.3.8 The provider shall:

A. Inform both the client and the KCMHP in writing of its decision about the grievance:

1. As expeditiously as the client's mental health condition requires, and

2. No more than 90 calendar days from the date of its receipt;

B. Along with this written decision, inform the client that further review at the KCMHP level is available, if requested within five calendar days, and shall provide instructions on how to make this request; and

C. Use Attachment B-2: Grievance Procedure Provider Tracking Form to ensure that grievance timelines are met. This form shall be kept with the provider grievance records with a copy faxed to KCMHP Client Services when the grievance activity is completed.

10.3.9 If the provider has not resolved a grievance from a Medicaid client within 90 days from receipt of the grievance, when Attachment B-2 is faxed to KCMHP Client services, the provider shall indicate on it the client address. KCMHP Client Services shall then send to the client the required Notice of Action.

10.3.10 If the client is unhappy with the provider decision, he/she may request a KCMHP review of the grievance.

A. This verbal or written request must be made to KCMHP Client Services within five calendar days of receipt of the provider written decision.

B. KCMHP shall acknowledge receipt of the request to review the provider grievance decision in accordance with item 10.4.4 below.

10.4 For all grievances reviewed by KCMHP, whether or not the client has a provider, the following shall occur:

10.4.1 The grievance shall be referred to a Grievance Committee composed of persons who have not been involved in any previous attempts to resolve this client's particular concern. For grievances involving clinical issues, the committee shall have at least one member with the appropriate clinical expertise that would be required to treat the client's condition or disease.

10.4.2 The provider, if one is involved in the grievance, shall send a copy of all written documentation relevant to the grievance and any preceding complaint within three business days.

10.4.3 KCMHP shall offer the client an opportunity to review any clinical records relevant to the grievance and to submit oral or written information about the grievance prior to the KCMHP decision on the grievance. The client will be informed that any such written documentation shall arrive no later than seven days prior to the Grievance Committee hearing.

10.4.4 The Grievance Committee shall schedule a hearing on a grievance at the earliest possible date, notifying all involved parties by letter at least seven days in advance of the scheduled date.

A. The client may invite representatives to the hearing.

B. The client and other involved parties shall be afforded the opportunity to present their grievance(s) and position(s).

C. Providers, if a part of the grievance, shall attend the grievance hearing to present their position with regard to the issues grieved.

10.4.5 The client and the provider shall be sent a copy of the written grievance decision as expeditiously as the client's mental health condition requires and:

A. No more than 90 calendar days after the filing of a grievance;

B. No more than within 30 calendar days of the filing of a grievance that does not involve a provider;

C. The client may request an additional 14 calendar days for the review of the grievance or, if KCMHP needs additional information for its review and justifies (to the satisfaction of DSHS upon its request) this is in the best interest of the client, it may extend the time to make its decision by an additional 14 calendar days;

1. The maximum time for completion of this stage of a grievance shall be 104 days; and

2. If the KCMHP extends the time, the client shall be told of the reason for the delay and, if a Medicaid client, also be given written notice of the reason for the delay;

D. Along with this written decision, KCMHP shall inform the client of his/her right to request a fair hearing at the state Office of Administrative Hearings, if requested, within 20 calendar days from the date of notice of an adverse ruling, and shall provide instructions on how to make this request; and

E. If KCMHP has not resolved a grievance from a Medicaid client within the time frames above, or fails to provide written notice of any extension by KCMHP, it shall send the client the required Notice of Action.

10.4.6 The Grievance Committee decision shall be binding on all parties involved in the grievance.

10.4.7 Prior to the Grievance Committee's determination, Client Services shall attempt to resolve the grievance to the satisfaction of the client. Should this occur, the client may withdraw the grievance.

11.0 MEDICAID CLIENT ACTION:

11.1 Definitions:

11.1.1 An Action for a Medicaid client is:

A. A denial or limited authorization of a requested, covered level of care: outpatient services, residential services, or inpatient day;

B. The reduction, suspension, or termination of a previously authorized level of care: outpatient services, residential services, or inpatient day;

C. The denial, in whole or in part, of payment for a previously authorized level of care: outpatient services, residential services, or inpatient day;

D. Client disagreement with the treatment plan;

E. The failure to provide services in a timely manner;

F. The failure of KCMHP to make an authorization decision within state-required timelines;

G. The failure to resolve a grievance within 90 days from the receipt of the grievance at the provider level and/or within 90 days from receipt at the KCMHP level and/or within 104 days from receipt at the KCMHP level if extended for an additional 14 days at the request of the Medicaid client or KCMHP as described above; or

H. The failure of KCMHP to resolve an appeal within the state-required timelines described below.

11.1.2 A denial is the decision by:

A. KCMHP to not authorize covered Medicaid mental health services that have been requested by a provider on behalf of a Medicaid client (also see 11.2.2 below); or

B. A provider or KCMHP not to offer an intake upon the request of a Medicaid client.

11.1.3 A suspension is the decision by KCMHP to temporarily stop a client's previously authorized covered Medicaid mental health services described in the Level of Care Guidelines. The clinical decision by a provider to temporarily stop or change a covered service in the Individual Service Plan (ISP) is not a suspension (see also 11.2.2 below).

11.1.4 A reduction is the decision by KCMHP to decrease a client's previously authorized covered Medicaid mental health services described in the Level of Care Guidelines. The clinical decision by a provider to decrease or change a covered service in the ISP is not a reduction (see also 11.2.2 below).

11.1.5 A termination is the decision by KCMHP to stop a client's previously authorized covered Medicaid mental health services described in the Level of Care Guidelines. The clinical decision by a provider to stop or change a covered service in the ISP is not a termination (see also 11.2.2 below).

11.1.6 Disagreement with the treatment plan occurs when a client indicates disagreement with specific treatment recommendations after all options for resolving the disagreement have been exhausted.

11.2 The following decisions by a provider are not considered to be an Action:

11.2.1 That services are not medically necessary and as a result no service authorization was requested of KCMHP:

A. Beyond the intake; or

B. To continue a previously authorized benefit;

11.2.2 Not to provide a requested covered service or to suspend, reduce, or terminate a covered service. Such a decision shall be fully documented in the client's clinical record and, should the client object to the decision, the client shall be reminded of complaint, grievance, and/or second opinion options.

KCMHP will generate a Notice of Determination for such decisions by a provider in accordance with the Notice of Determination procedures below.

11.3 The following activities are considered authorization decisions by KCMHP and may constitute an Action when adverse to a client:

11.3.1 For inpatient services

A. KCMHP (or its contracted designee) may approve or deny provider (including hospital provider) requests for an admission or length of stay extension;

B. KCMHP (or its contracted designee) may approve or deny payment for a hospital day retrospectively; and

C. Once given, inpatient authorizations are not terminated, suspended, or reduced (however, unless otherwise specified, an authorization expires when 24 hours have passed without the client receiving hospital services).

11.3.2 For outpatient services

A. The Mental Health, Chemical Abuse and Dependency Services Division Information System (MHCADSD IS) electronically approves or denies a provider request for outpatient services when the provider submits a complete and timely dataset documenting eligibility and medical necessity;

B. MHCADSD IS electronically approves a provider request for termination of outpatient services when the provider submits a complete request for termination;

C. KCMHP clinical team approves or denies a 3B case rate request. However, this is considered an Action only if the staff person determines that the client does not meet medical necessity for any outpatient services; or

D. KCMHP clinical team concur with or overturns, through a grievance reviewed at the KCMHP level, a provider decision to deny, reduce, suspend, or terminate outpatient services.

11.3.3 For residential services

A. MHCADSD IS electronically approves or denies a provider request for residential services when the provider submits a complete and timely dataset documenting eligibility and medical necessity;

B. MHCADSD IS electronically approves a provider request for termination of residential services when the provider submits a complete request for termination from all types of residential services; or

C. KCMHP clinical team concur with or overturns, through a grievance reviewed at the KCMHP level, a provider decision to deny, reduce, suspend, or terminate from all types of residential services.

11.3.4 A change from residential to non-residential, and solely outpatient services, is considered a reduction of the previously authorized residential service; and

11.3.5 The following events are not Actions for a Medicaid client (and therefore cannot be appealed):

A. The assignment of a particular case rate, a particular residential facility or type of residential service, or an outpatient carveout, either by the provider or KCMHP;

B. The assignment of the administrative daily rate for an inpatient day;

C. The failure to authorize a request due to a provider failure to provide adequate information; or

D. The withdrawal of a request for inpatient services, either by the client or the provider. This includes a negotiated diversion from an inpatient admission.

12.0 NOTICE OF DETERMINATION:

12.1 Medicaid and non-Medicaid Notices of Determination

12.1.1 Authorization of services

A. Clients shall receive a written Notice of Determination when authorized for the outpatient level of care.

B. Such notice will include:

1. Services authorized; and

2. Dates during which the services may occur.

C. The notice shall be created by KCMHP at the time of the authorization and mailed by KCMHP to the client. Providers may be asked to deliver the notice should KCMHP be unable to do so, due to lack of a mailing address.

1. Timeline for the delivery is within 14 working days of the authorization decision.

2. The provider shall document in the clinical record the delivery of the notification to the client whenever asked to make the delivery.

3. See Attachment C: Notice of Determination for Authorization of Services for Medicaid and Non-Medicaid Clients.

12.2 Notices of Determination for Clients funded by State-Only Funds (i.e., State-Funded)

12.2.1 Clients shall receive a written Notice of Determination when:

A. Services have been denied because:

1. A provider or KCMHP does not offer an intake upon request to a State-Funded client who meets First Priority criteria; or

2. A provider request for the authorization of services is denied by KCMHP based on:

a. Medical necessity (Level of Care Guidelines); or

b. Lack of available resources, even if the client meets medical necessity;

B. KCMHP authorized services are reduced, terminated, or suspended by KCMHP due to:

1. The reasons described in section 14.7.2 below and the provider's submittal to MHCADSD IS of appropriate exit reasons; or

2. Lack of available resources, even if the client meets medical necessity;

C. Clients funded by resources other than State Funds (e.g., local sales tax revenues, private insurance, etc.) are not sent the Notice of Determination as described in this section.

12.2.2 The notice shall be created by KCMHP at the time of the decision and mailed by KCMHP to the client. Providers may be asked to deliver the notice should KCMHP be unable to do so, due to lack of a mailing address.

A. Timeline for the delivery of a Notice of Determination

1. Denial of requested services is in accordance with Section 14.7.1 below.

2. Reduction, termination, or suspension of services is in accordance with section 14.7.2 below.

3. For terminations due to loss of Medicaid coverage:

a. The Notice of Determination shall be delivered no later than 14 days after KCMHP determines the client has no Medicaid coverage and that the person will not be continuing services in a State-Funded benefit or a non-payment status; and

b. The effective date of termination shall be the first day of the month in which the client no longer has Medicaid coverage (see Section VI: Outpatient Services Level of Care).

12.2.3 The Notice of Determination will include:

A. Reason for the denial of requested services or the reduction, termination, or suspension of KCMHP previously authorized services;

B. If it is a denial based on lack of medical necessity, the right to a second opinion and how to access one and priority criteria for services (see Section VI: Outpatient Services Level of Care);

C. The right to file a grievance with KCMHP and that it must be filed:

1. Within 20 days of the date on the Notice of Determination; or

2. Within 10 days of the date on the Notice of Determination if previously authorized services are being reduced, terminated, or suspended and the client wants services to be continued during the grievance and fair hearing processes. The notice will also include criteria for such a request (see Section 16 below); and

D. The right to a state fair hearing.

12.2.4 During the 0 to 20 days allowed for a client to request a grievance, the provider is responsible for providing crisis care to the client, if requested by the client.

12.2.5 When termination of either an outpatient or residential benefit occurs, the procedures for payment in Section 14.5 below shall apply.

12.2.6 See Attachment E: Notice of Determination for Denial, Reduction, Termination, or Suspension of Services for State-Funded Clients.

13.0 NOTICES TO CHILDREN WITH A "D" COUPON:

13.1 For a child with a "D" coupon (foster care), when either an intake is denied or services beyond the intake have not been authorized, a Notice of Determination (see above) or Notice of Action (see below) as required shall be sent by KCMHP as follows:

13.1.1 The legal representative that must receive the notices for a child with a "D" coupon is the Children's Administration Regional office; and

13.1.2 A copy of such notice will be mailed to DSHS at the same time it is provided to the client or the client's representative.

14.0 MEDICAID CLIENT NOTICE OF ACTION:

14.1 When an action occurs regarding the care of a Medicaid client, a fully completed Notice of Action form (see Attachment F: Notice of Action for Medicaid Clients) will be:

14.1.1 Mailed to the client; and

14.1.2 Sent electronically to the provider, if a provider has requested the service on behalf of the client.

14.2 The Notice of Action will:

14.2.1 Be in writing and, as appropriate, provided on the prevalent non-English language forms as provided by DSHS;

14.2.2 Be mailed to the client promptly as defined in the procedures below;

14.2.3 Include information describing the Action, the rationale for the decision, the right to a second opinion and how to access one, and directions for appealing the decision. See Attachment F: Notice of Action for Medicaid Clients; and

14.2.4 Include information about the availability of other services under Early Periodic Screening, Diagnosis, and Treatment (EPSDT) for Medicaid clients under age 21 and their legal representative. (See Attachment G: Accessing Medical Care Covered by Medicaid and EPSDT Rights for Children.)

14.3 The responsibility for identifying when a Notice of Action should be mailed to the client is as follows:

14.3.1 For adverse inpatient authorization decisions that constitute an action, the KCMHP inpatient designee making the authorization decision alerts KCMHP staff to mail the Notice of Action;

14.3.2 For adverse authorization decisions made by KCMHP that constitute an action as described above, KCMHP staff shall mail the Notice of Action;

14.3.3 KCMHP staff shall be alerted within three business days to mail a Notice of Action by the Outpatient provider as follows:

A. The provider shall fax a copy of the first page of the Notice of Action, completely filled out, to KCMHP Client Services, including with it the client's current address, whenever the provider:

1. Does not provide an intake upon request by a Medicaid client (see Attachment I: Failure to Offer Intake to a Medicaid or Apparently Eligible State-Funded Client or Failure to Request Authorization When a Client Meets Medical Necessity Criteria);

2. Does not request an authorization following an intake when a Medicaid client is determined to meet medical necessity (see Attachment I: Failure to Offer Intake to a Medicaid or Apparently Eligible State-Funded Client or Failure to Request Authorization When a Client Meets Medical Necessity Criteria);

3. Is informed of a Medicaid client's disagreement with his or her treatment plan (see Attachment D: Notice of Action Disagreement with Treatment Plan); or

4. Does not resolve a grievance within the required time frames.

B. By submittal to MHCADSD IS from the provider of the appropriate transaction and Current Procedural Terminology (CPT) codes for when a client doesn't meet medical necessity (see Section VI: Outpatient Services Level of Care) and the provider does not request services or authorization beyond:

1. The intake, or

2. Previously authorized services (see Attachment F: Notice of Action for Medicaid Clients).

14.4 KCMHP (or, for inpatient, its designee) shall send a copy of the Notice of Action to the KCMHP provider, if the provider has made the authorization request on behalf of a client.

14.5 When a termination of either an outpatient or residential benefit occurs, in order that the payment to a provider is accurately claimed, the following shall occur:

14.5.1 The provider electronically submits the notice of exit transaction and, for a client who has moved out of King County, submits a change of zip code and Community Service Office (CSO), effective as follows:

A. For the termination of outpatient benefits, effective the date of the:

1. Client's death;

2. Change of residence outside the RSN; or

3. Fulfillment of one of the allowed-termination criteria; and

B. For the termination of a residential benefit, effective the date the client moves out of the residential level of care;

14.5.2 KCMHP shall mail any needed Notices of Action or send any needed Notices of Determination;

14.5.3 After allowing any required time (0 to 20 days) for a client appeal (see below):

A. If the client does not appeal, no further action is needed; and

B. If the client does appeal, KCMHP shall contact the provider, arrange a continuation of services if requested by the client, and arrange for any needed payments, authorizations, or electronic transactions; and

14.5.4 If a client appeal reverses a termination of a benefit:

A. For an outpatient benefit, KCMHP staff shall reinstate the benefit, backdating as needed; or

B. For a residential benefit, the residential provider shall request a new authorization and backdate as needed.

14.6 During the 0 to 20 days allowed for a client to request an appeal, the provider is responsible for providing crisis care to the client, if requested by the client.

14.7 The Notice of Action shall be mailed within the following time frames:

14.7.1 For denial of services requested or client disagreement with treatment plan:

A. The Notice of Action shall be mailed as expeditiously as the client's condition requires and within 14 calendar days of:

1. The submission of a request for services;

2. KCMHP receipt of notification from a provider that a Medicaid client:

a. Was not provided an intake;

b. Requested services and the provider determined medical necessity was not met and did not request an authorization for services; or

c. Requested services and the provider determined medical necessity was met but did not request an authorization for services; or

3. The Medicaid client's disagreement with treatment plan;

B. An additional 14 calendar days may be taken if:

1. The client or provider requests the extension; or

2. KCMHP justifies (to the state DSHS upon request) a need for additional information and how the extension is in the client's interest. If the KCMHP takes this additional time, it shall tell the client in writing the reason for doing so and inform him/her that he/she has the right to file a grievance if he/she is in disagreement with this delay;

14.7.2 For the termination, reduction, or suspension of previously authorized covered services, the Notice of Action shall be mailed at least 10 calendar days prior to the effective date for the termination, reduction, or suspension. Certain exceptions from advance notice are allowed as follows:

A. The Notice of Action can be mailed as late as the effective date for the termination, reduction, or suspension when:

1. The client has sent a signed statement:

a. Saying that he/she no longer wishes services; or

b. Providing information that requires a termination, reduction, or suspension of services and indicating that he/she realizes that this shall be the result of sending this information;

2. The client has been admitted to an institution where he is ineligible under the plan for further services;

3. The client's whereabouts are unknown and the post office has returned agency mail stating there is no known forwarding address;

4. The client has been accepted for Medicaid services in another PIHP or state;

5. The Notice of Action involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act; or

6. The date of the action shall occur in less than 10 days, in accordance with Sec. 483.12(a) (5) (ii);

B. The Notice of Action can be mailed as late as five days prior to the effective date for the termination, reduction, or suspension when the PIHP has facts indicating that action should be taken because of probable fraud by the client and, if possible, these facts have been verified;

C. The Notice can be mailed an additional 14 calendar days later if:

1. The client or provider requests the extension; or

2. KCMHP justifies (to the state DSHS upon request) a need for additional information and how the extension is in the client's interest. If the KCMHP takes this additional time, it shall tell the client in writing the reason for doing so and inform him/her that he/she has the right to file a grievance if he/she is in disagreement with this delay. Further, KCMHP will issue and carry out its determination as expeditiously as the client's health condition requires and no later than the date the extension expires;

D. For denial of payment, the Notice of Action shall be mailed at the time of the denial;

E. See Section VII: Residential and Supportive Housing Services Level of Care, for additional requirements for Notices of Action for clients receiving the residential level of care;

F. For service authorization decisions not reached within the time frames in Section 14.7.1 above (which constitutes a denial and thus an adverse action), on the date that the time frames expire; and

G. For expedited service authorization decisions, within three working days after receipt of the request for service, unless the 3 working days time frame has been extended by up to 14 calendar days.

14.8 See Attachment H: When to Send a Notice of Determination or Notice of Action for a summary of notice requirements.

15.0 MEDICAID CLIENT APPEAL (IN RESPONSE TO A NOTICE OF ACTION):

15.1 Definition: An appeal is a request for a review of any Action and is a term that applies only to Medicaid clients.

15.2 The steps in an appeal are as follows:

15.2.1 The client files the appeal with the KCMHP

A. In most instances, the client must file the appeal within 20 days of the date on the Notice of Action.

B. However, for appeals about previously authorized services that are being terminated or reduced and when the client wishes the services to continue, the client shall file the appeal within 10 days of the date on the Notice of Action.

C. A KCMHP provider, acting on behalf of a client and with the client's written consent, may file the appeal.

D. The client may have any representative of his/her choice as a party to an appeal. When applicable, the legal representative of a deceased client's estate may file an appeal.

15.2.2 The appeal may be filed either by phone or in writing. Appeals that are initiated by phone must be followed with a written statement of the appeal within seven calendar days. The written statement should include, at a minimum, the client's name, how best to contact him/her, the reason for the appeal, and any evidence the client wishes to submit. The statement shall be signed by the client (or parent or guardian).

15.2.3 The date of receipt of an appeal is the first business day on which a verbal or written appeal is received.

A. If a phone message or letter initiating an appeal arrives on a non-business day, the date of receipt is the next business day.

B. When a verbal request precedes a written request regarding the same appeal, the date of receipt is the date of the verbal request in order to establish the earliest possible filing date for the appeal.

15.2.4 Within one business day of the KCMHP receipt of the appeal, acknowledgement the appeal shall occur as follows:

A. If the client has requested the appeal verbally, he/she shall be both phoned and mailed a letter verifying that the request has been received and informing him/her that the appeal must also be submitted in writing in accordance with Section 15.2.2 above; and

B. If the client requested the appeal in writing, he/she shall be mailed a letter verifying that the request has been received.

15.2.5 The written acknowledgement shall include:

A. The date of receipt of the appeal;

B. A description of the appeal process, including timelines and opportunities for client input; and

C. A description of the client's right to continue services through the appeal process (see below).

15.2.6 In the acknowledgement, KCMHP shall offer the client a minimum of three business days to informally discuss the appeal before the client decides to continue the appeal process.

15.2.7 All appeals shall be reviewed by a KCMHP clinical team mental health professional or a KCMHP medical director who shall be a person not previously involved in the action being appealed.

15.2.8 The client and/or his/her representative may look at any KCMHP records used to make the authorization decision that is being appealed in order to prepare his/her appeal. Such records may be reviewed both before and during the appeals process.

15.2.9 The client shall submit any information, statements, or other evidence regarding his appeal within 30 calendar days of the initial filing of the appeal. Information may be submitted in writing or in person.

15.2.10 The KCMHP shall send a written decision about the appeal to the client within 45 calendar days from the date of its receipt. The client may request an additional 14 calendar days for the review of the appeal or, if KCMHP needs additional information for its review and justifies to satisfaction of the state DSHS upon its request this is in the best interests of the client, it may extend the time to make its decision by an additional 14 calendar days (the maximum allowed time for a decision is 59 calendar days). If the KCMHP extends the time, the client shall be given written notice of the reason for the delay.

15.2.11 If KCMHP fails to resolve the appeal within the above time frames or fails to provide written notice of any delay by KCMHP, it shall send a Notice of Action to the client.

15.2.12 The written decision shall include the following:

A. The results of the appeal;

B. The date of completion of the appeal; and

C. If the decision is not wholly in the client's favor:

1. The right to request a state fair hearing, how to do so, and the deadline for doing so;

2. The right to continue services while the hearing is pending and how to make this request (see below); and

3. The fact that the client may be held liable for the cost of the services if the state fair hearing decision upholds the KCMHP determination.

15.2.13 If the client, the client's representative, or a provider thinks that taking the time for a standard resolution could seriously jeopardize the client's life or health or ability to attain, maintain, or regain maximum function, an expedited appeal may be requested.

A. An expedited appeal may be filed by phone and does not require a follow-up written statement.

B. A request for an expedited appeal in which the provider agrees that the appeal should be expedited shall be resolved within three business days. In addition to immediately sending a written statement of the appeal results to the client, KCMHP shall make reasonable efforts to phone him/her with the decision.

C. A request for an expedited appeal that comes from the client or the client's representative, without provider agreement that it be expedited, will be resolved within three business days, if the KCMHP clinical team mental health professional determines a need for expediency. If the KCMHP clinical team mental health professional does not determine a need for expediency, it shall so inform the client immediately by phone and follow up within two calendar days with a written statement which explains the reason for the delay, inform the client that the appeal shall be processed according to the usual time frames, and inform the client that he/she may file a grievance regarding the denial of expediency.

D. When the decision is made to expedite an appeal, the client shall be notified of the limited time available to present evidence in person and/or in writing.

E. KCMHP shall ensure that punitive action is not taken against a KCMHP provider who files for or supports a client's request for expediency.

F. Appeals for routine outpatient care need not be expedited when available crisis services can meet the medically necessary needs of the client.

15.2.14 A client who is unhappy with the KCMHP review of an appeal may ask that the appeal be reviewed by the state Office of Administrative Hearings. This is called a state fair hearing (see below).

15.3 Appeals by State-Funded clients

15.3.1 The above-described appeal processes are not available to State-Funded clients. A State-Funded client who wishes to appeal an authorization decision may instead file a grievance.

16.0 CONTINUATION OF SERVICES DURING THE GRIEVANCE OR APPEAL PROCESSES:

16.1 During a grievance or appeal process, previously authorized services shall continue to be provided based on usual eligibility and medical necessity criteria unless the grievance or appeal involves the denial, reduction, suspension, or termination of previously authorized services.

16.2 If the grievance or appeal involves the denial of services, services shall not be continued as none have been authorized.

16.3 For Medicaid Clients, if an appeal involves the reduction, suspension, or termination of previously authorized services, a client may request to continue services during the KCMHP appeal and state fair hearing processes, if:

16.3.1 The appeal arrived in time as follows:

A. Within 10 calendar days of the date on the Notice of Action; or

B. On or before the effective date of the action;

16.3.2 The authorization has not expired;

16.3.3 The services are considered medically necessary by a KCMHP provider; and

16.3.4 The client requests that the services be continued. This request may be made orally or in writing.

16.4 For State-Funded clients, if a grievance involves the reduction, suspension, or termination of previously authorized services, a client may request to continue services during the KCMHP grievance and state fair hearing processes, if:

16.4.1 The grievance arrived within 10 calendar days of the date on the Notice of Determination; and

16.4.2 The services were provided by a KCMHP provider and the client requests that the services be continued. This request may be made orally or in writing.

16.5 If services are continued as above per client request, the client shall agree in advance to pay for any continued services received should the grievance or appeal resolution uphold the reduction, suspension, or termination of services. However, in some circumstances, KCMHP may waive this requirement. The KCMHP shall provide the client an estimate of the cost of these services, which is the amount the KCMHP anticipates paying the provider or the amount that the provider shall charge the client according to its sliding fee scale.

16.5.1 If the client agrees to the above, the provider must continue the previously authorized services.

A. The provider shall receive payment through the usual payment mechanisms, as long as an authorization remains in place.

B. If an authorization expires and continuation of services is still required, the provider may submit a bill to KCMHP for the unpaid services at the end of the month for an amount equal to the case rate the provider was receiving under the expired authorization.

C. If KCMHP has not waived the requirement that the client pay for services in the event that the grievance or appeal is unsuccessful and it is unsuccessful, the provider shall attempt to collect payment from the client. The amount charged the client should be the daily case rate paid by KCMHP to the provider or the amount the provider would charge a client under its sliding fee scale for State-Funded clients, whichever is the lower amount. Should payment be received, the provider shall reimburse KCMHP.

16.5.2 If the client does not agree to the above and the KCMHP does not waive the requirement, the provider shall implement the planned reduction, suspension, or termination of services.

16.6 When the above requirements are met and the client requests services, the services shall be continued at least until:

16.6.1 The grievance or appeal is withdrawn;

16.6.2 For appeals, the time period or service limits of a previously authorized service has been met;

16.6.3 The grievance or appeal has been denied by the KCMHP, the client has been so notified, and any deadline has passed for requesting a state fair hearing;

16.6.4 The grievance or appeal has been denied by the state Office of Administrative Hearings (OAH); or

16.6.5 The client withdraws the request to continue services.

16.7 If a grievance or appeal involves the reduction, suspension, or termination of previously authorized Medicaid-covered services and the final decision for reduction, suspension, or termination is:

16.7.1 Upheld and the payment requirement has not been waived, the KCMHP may attempt to collect payment for services from the client; or

16.7.2 Overturned and the client has opted not to continue services during the grievance or appeal process, medically necessary treatment shall be resumed as expeditiously as the client's mental health condition requires and no later than 14 calendar days from the overturning decision.

16.8 If a grievance or appeal involves the denial, limit, or delay of services that were not provided while the appeal was pending, the KCMHP shall immediately authorize the services and ensure that they occur as expeditiously as the client's mental health condition requires and no later than 14 calendar days from the overturning decision.

16.9 If the grievance or appeal involves a denial of services which the client has received while the appeal was pending, the KCMHP shall pay for those services in accordance with state policy and regulations.

16.10 All clients may access crisis services (through the crisis system, not the outpatient provider), irrespective of ability or willingness to pay, during a grievance or appeal process.

17.0 STATE FAIR HEARINGS:

17.1 Clients and their representatives have the right to use the pre-hearing and administrative hearing processes described in Chapter 388-02 WAC or its successor.

17.2 A fair hearing, through the state OAH, may be requested when:

17.2.1 A client believes there has been a violation of a DSHS rule;

17.2.2 KCMHP does not provide a written response to a grievance or appeal within the required time frames;

17.2.3 A client receives an adverse ruling by KCMHP of a grievance; or

17.2.4 A Medicaid client receives an adverse ruling by KCMHP of an appeal.

17.3 Hearings may be initiated by calling 1-800-583-8271.

17.4 Clients may request assistance with a fair hearing from a provider who is acting on the client's behalf, the Ombuds office, Client Services, his/her representative, or any other advocate. If the client is deceased, the representative of his/her estate may initiate a hearing.

17.5 The client shall file the hearing request within 20 calendar days of receiving the adverse resolution of his/her grievance or appeal to KCMHP.

17.6 Evidence and/or allegations of fact or law may be presented in writing and/or in person to the OAH according to their procedures.

17.7 The OAH decisions are binding on KCMHP and the provider.

17.8 Services may be continued during the state fair hearing process according to the procedures above.

17.9 KCMHP shall participate as required in state fair hearings and implement the final orders of the administrative judge.

18.0 PROVIDER TRAINING:

18.1 Training on grievance system policies and procedures shall occur during KCMHP staff/provider meetings.

18.2 Additional training is available on request to Client Services.

19.0 COMPLIANCE MONITORING AND REPORTS:

19.1 During a grievance or appeal process, KCMHP shall provide oversight to ensure that:

19.1.1 Services are continued according to the above requirements;

19.1.2 Timelines for decision are met as required; and

19.1.3 No retaliation occurs.

19.2 KCMHP shall monitor the compliance of all parties to grievance or appeal decisions.

19.3 KCMHP shall monitor for implementation of all procedures.

19.4 Providers shall send to Client Services documentation of compliance with the grievance or appeal decision within 30 days or sooner if requested in the written decision.

19.5 KCMHP shall follow up with all clients who have filed grievances or appeals to ensure that no retaliation has occurred.

19.6 KCMHP shall keep documentation on all grievances or appeals for at least six years. The information shall be reviewed at least annually and used to improve service delivery.

19.7 Providers will report all grievances, denials, and their resolutions to KCMHP, providing one report on Medicaid recipients and one report on all others. Reports are due on the dates specified in the contract. (See formats in Attachment B-1.)

19.8 The KCMHP shall report to DSHS on the dates specified in the state contracts on:

19.8.1 The number and nature of all grievances, denials, appeals, and fair hearings;

19.8.2 The time frame required to dispose or resolve each one;

19.8.3 The nature of the resolution decisions; and

19.8.4 A summary and analysis of the data, including the identification of any trends and any measures taken to address undesirable trends.

20.0 LIST OF ATTACHMENTS:

20.1 Attachment A: Client Rights – Outpatient Services

20.2 Attachment A-1: Client Rights: How to Promote and Protect Them

20.3 Attachment A-2: Mental Health Advance Directives: What Clinicians Need to Know

20.4 Attachment B-1a: Grievance System Reporting Instructions

20.5 Attachment B-1b: Grievance Report – Medicaid-Funded Services

20.6 Attachment B-1c: Grievance Report – State-Funded Services

20.7 Attachment B-2: Grievance Procedure Provider Tracking Form

20.8 Attachment C: Notice of Determination for the Authorization of Services

20.9 Attachment D: Notice of Action for Disagreement with Treatment Plan

20.10 Attachment E: Notice of Determination for Denial, Reduction, Termination, or Suspension of Services for State-Funded Clients

20.11 Attachment F: Notice of Action for Medicaid Clients

20.12 Attachment G: Accessing Medical Care Covered by Medicaid and EPSDT Rights for Children

20.13 Attachment H: When to Send a Notice of Determination or Notice of Action

20.14 Attachment I: Failure to Offer Intake to a Medicaid or Apparently Eligible State-Funded Client or Failure to Request Authorization When a Client Meets Medical Necessity Criteria

21.0 REFERENCES:

Federal Law, Regulations, and policy including any successor, amended, or replacement laws, regulations, or policies

- 42 CFR Part 438 Managed Care
- 42 CFR Parts 400, 430, 431, 434, 435, 440
- 45 CFR Part 142 Security and Electronic Signature Standards
- 45 CFR parts 160 and 164 Standards for Privacy of Individually Identifiable Health Information
- 45 CFR Part 162 Health Insurance Reform: Modifications to Standards for Electronic Transactions and Code Sets.
- 25 United States Code (USC) 479 Indians – Definitions
- 42 USC 12131 (Americans with Disabilities Act of 1990)

Washington State Law, Regulations, and Policy including any successor, amended, or replacement laws, regulations, or policies

- Chapter 388-02 WAC – Department of Social and Health Services – DSHS Hearing Rules
- Chapters 388-865, 388-877, and 388-877A WAC – Department of Social and Health Services – Mental Health – Community Mental Health and Involuntary Treatment Programs
- Chapter 34.05 RCW – Administrative Law – Administrative Procedure Act

- Chapter 49.60 RCW – Labor Regulations – Discrimination – Human Rights Commission
- Chapter 71.32 RCW – Mental Illness – Mental Health Advance Directives
- Federal 1915(b) Waiver Renewal

Other

- The current Department of Social and Health Services (DSHS) State Mental Health Contract and any subsequent amendments
- The current Department of Social and Health Services (DSHS) PIHP Contract and any subsequent amendments

King County Regional Support Network (RSN)
Rights for Clients Receiving Outpatient Services

What are My Rights as a Person Receiving Public Mental Health Services in the community?

- To be treated with respect and dignity.
- To have your privacy protected.
- To help develop a plan of care with services to meet your needs.
- To participate in decisions regarding your mental health care.
- To receive services in a barrier-free location (accessible).
- To request information about names, location, phones, and languages for local agencies.
- The right to receive the amount and duration of services you need.
- To request information about the structure and operation of the RSN.
- The right to services within 2 hours for emergent care and 24 hours for urgent care.
- To be free from use of seclusion or restraints.
- To receive age and culturally appropriate services.
- To be provided a certified interpreter and translated material at no cost to you.
- To understand available treatment options and alternatives.
- To refuse any proposed treatment.
- To receive care that does not discriminate against you (e.g. age, race, type of illness).
- To be free of any sexual exploitation or harassment.
- To receive an explanation of all medications prescribed and possible side effects.
- To make an advance directive that states your choices and preferences for mental health care.
- To receive quality services that are medically necessary.
- To have a second opinion from a mental health professional.
- To file a grievance with your agency or RSN.
- To file a RSN appeal based on a RSN written Notice of Action.
- To choose a mental health care provider or choose one for your child who is under thirteen years of age.
- To change mental health care providers during the first 90 days, and sometimes more often.
- To file a request for an administrative (fair) hearing.
- To request and receive copy of your medical records and ask for changes.
- To be free from retaliation.
- To be informed that research concerning clients whose costs of care is publicly funded must be done in accordance with all applicable laws, including state rules on the protection of human research subjects.
- To discuss a concern with the Ombuds service, regional support network, or provider if you believe your rights have been violated. If you discuss a concern or file a grievance or an appeal, you must be free of any act of retaliation. The Ombuds may, at your request, assist you in resolving your concerns.

You may want to ask your mental health care provider for more information about your rights. You have the right to request policies and procedures of the RSN and community mental health agencies as they pertain to your rights.

Client Rights: How to Promote and Protect Them
King County Regional Support Network

Purpose and Requirements

To ensure:

All clients receiving publicly funded mental health services are:

- Informed of their rights
- Able to understand their rights
- Free to exercise their rights without fear of reprisal.

Client rights are protected

State and Federal Regulations Governing Rights

State:

- Chapters 388-865, 388-877, and 388-877A Washington Administrative Code
- Chapters 71.05, 71.24, and 71.34 Revised Code of Washington
- State Department of Social and Health Services (DSHS) contracts with the RSN

Federal:

- 42 Code of Federal Regulations, Part 438 Managed Care (Medicaid)

Rights must be Posted

At facility locations where clients will be able to view them easily

In each of the state Department of Social and Health Services (DSHS) prevalent languages:

- Cambodian, Chinese, Korean, Laotian, Russian, Somali, Spanish, Vietnamese
- Copies may be downloaded from the King County RSN Intranet at:
  - http://www.kingcounty.gov/healthservices/MentalHealth/Plans/brochure.aspx

Frequency

When should clients be informed of their rights?

- By the clinician
  - When outpatient or residential services are initiated
- By the RSN
  - When services are authorized and at annual re-authorization
  - The RSN will include a copy of the client rights with the authorization notice

Understanding of Rights

Rights must be presented in:

- The client's primary language either in print or read to the client by an interpreter.
- Alternate format (e.g., large print, audio CD, DVD, or other format acceptable to the client) upon request.

Documented in the clinical record

By client signature

Indicate if rights were provided in the client's primary language or an alternate format

What if the client is incapacitated?

If the client is unable to understand his or her rights due to incapacity:

- Provide information to client's family or representative, if available,
- Re-offer to the client if and when capacity is regained.

Individual Rights – How to promote and protect each right	
People receiving public mental health services in the community have the right to:	Staff members should:
Be treated with respect and dignity	See clients as individuals, not cases or diagnoses. Treat clients with the courtesy, fairness, and kindness staff themselves would want to receive. Recognize the talents and capabilities of the client. Listen to and support the client. This right is most frequently the subject of a grievance – it is based on how a client perceives he or she has been treated.
Have their privacy protected	Conduct confidential conversations in areas where they can't be overheard: • Waiting rooms, intake desks, offices Keep personal information out of public site: • Computer monitors, charts, data entry documents are not visible Give client the King County HIPAA Notice of Privacy Practices Comply with HIPAA and other confidentiality requirements related to the: • Release, exchange, transmission, and storage of client information
Help develop a plan of care with services to meet their needs	Develop an Individual Service Plan (ISP) collaboratively with the authorized client that: • Meets the client's unique needs • Is consumer-driven and strength-based Include the client in updates to his or her plan
Participate in decisions regarding their mental health care	Encourage client to express preferences about future treatment decisions Review and update the ISP in consultation with the client • At least every 180 days • More often at the request of the client
Receive services in a barrier-free location (accessible)	Ensure clients can participate in mental health services: • Regardless of disability, e.g., limited mobility or sensory impairment ▪ Facilities are compliant with the Americans with Disabilities Act ▪ TTY communication devices available ▪ Interpreters are provided for hearing impaired or limited English proficient clients • Bring services to consumers or service sites where there is limited transportation
Request information about names, location, phones, and languages for local agencies	Inform clients at time of intake they may receive, upon request, a copy of the following documents that contain this information: • The King County RSN Brochure, Public Mental Health Services in King County, for all clients • The state DSHS Benefits Booklet for People Enrolled in Medicaid, for Medicaid clients only
Receive the amount and duration of services they need	Assist clients to achieve the goals stated in their individual service plans Provide access or referral to medically necessary services Applies to: • All Medicaid clients who meet access to care criteria • Non-Medicaid clients who meet access to care criteria and for whom funding is available

Individual Rights – How to promote and protect each right	
Request information about the structure and operation of the RSN	Inform clients if they want to make this request to call: • King County RSN Client Services: ▪ 206-263-8997 ▪ 1-800-790-8049 ▪ TTY 206-205-0569
Services within 2 hours for emergent care and 24 hours for urgent care	Inform authorized clients of: • Crisis services available from community mental health agency, including after-hours crisis support • When and how to use designated crisis number • Provide client with a wallet card with crisis information People not currently receiving services should call the 24-hour Crisis Line at: • 206-461-3222 • 1-866-427-4747 • TTY 206-461-3219
Be free from use of seclusion or restraints	Seclusion and restraint: • Cannot be used as a means of: ▪ Coercion, discipline, convenience, or retaliation • Includes: ▪ Chemical restraint ▪ Anything that keeps a client from moving about on his or her own • May only be used in a facility certified to do so (hospital, E&T, nursing home, Residential Treatment Facility): ▪ To protect the client or others when all other interventions have been determined ineffective ▪ For the shortest time possible
Receive age and culturally appropriate services	Inquire of client with which cultures he or she identifies Ensure clinical consultation with appropriate mental health specialist(s)
Be provided at no cost a certified interpreter and translated material	Provide an interpreter in the language the client prefers to communicate Provide translated materials in: • DSHS prevalent languages for: ▪ King County RSN Brochure, Client Rights, & Notice of Privacy Practices ▪ DSHS Benefits Booklet for People Enrolled in Medicaid ▪ Notices of Determination / Action (RSN responsibility) • Spanish for the community mental health agency's: ▪ Application for services ▪ Consent forms
Understand available treatment options and alternatives	Provide information to the client: • About other commonly available treatment options, whether or not they are available from the agency: ▪ Alternative treatments • Dialectical Behavior Therapy, Transcranial Magnetic Stimulation ▪ Other treatments that may be self-administered • Alcoholics Anonymous, self-help and/or support groups • To assist client in choosing among relevant treatment options, including the: ▪ Risks, ▪ Benefits, and ▪ Consequences of treatment and non-treatment

Individual Rights – How to promote and protect each right	
Refuse any proposed treatment	Ask clients if they want to: • Get treatment • Take medication Provide information about how treatment or medications may help Provide information about adverse effects Answer questions the client may have Honor the client's decision to refuse
Receive care that does not discriminate against them	Ensure clients are not discriminated against due to their: • Race • Color • Sex • Religion • National origin • Sexual orientation • Age • Disability (sensory, mental, or physical) • Type of illness • Willingness to provide information about these personal characteristic
Be free of any sexual exploitation or harassment	Let clients know sexual exploitation or harassment by staff or other clients will not be tolerated by the agency Provide client information about and assistance in reporting such an event
Receive an explanation of all medications prescribed and possible side effects	Inform clients they can ask their prescriber about their medications and possible side effects Ask the client if he or she is experiencing any side effects Advocate for the client if necessary
Make an advance directive that states their choices and preferences for mental health care	Give each adult and emancipated minor client written information about: • How to execute an advance directive • A brief description of the State law Ensure clients have a voice in developing their advance directive For medically compromised clients: • Identify if the client has a "medical" advance directive • If so, obtain a copy and keep on file
Receive quality services that are medically necessary	Ask clinically relevant questions of the client to determine if the services requested are medically necessary Review the ISP periodically with the client to determine if services are assisting the client to achieve his or her goals
Have a second opinion from a mental health professional	Assist the client to obtain a second opinion from another mental health professional within your agency Ensure a second opinion: • Occurs within 30 days of request • Is provided at no cost to the client Submit any requests to obtain a second opinion from a different mental health agency to King County Client Services
File a grievance with your agency	If a client is not satisfied with his or her services, provide information on: • How to file a grievance (grievance must be in writing) • Assistance available from the agency, the Ombuds, or King County Client Services • Time lines for each step in the process • How to request authorized services be continued during the grievance process • What the client can do if he or she disagrees with the decision

Individual Rights – How to promote and protect each right	
File a RSN appeal based on a RSN written Notice of Action	If a client receives a Notice of Action from the RSN: • And the client wishes to file an appeal, inform the client: ▪ Of how to request assistance with the appeal from the Ombuds or King County Client Services ▪ That services can be continued during the appeal process if time frames on the notice are followed • The agency may file an appeal on behalf of a client with the client's written consent
Choose a mental health care provider or choose one for their child who is under 13 years of age	Offer clients who request services: • A choice of mental health care providers (care coordinator/ care manager/therapist) from available staff within the agency • If services are requested for a child under age 13, the choice should be offered to the child's parents Respect the client's choice If the client does not make a choice: • The mental health agency must assign a mental health care provider • Within 14 days from when the client requested services
Change mental health care providers during the first 90 days and sometimes more often	Inform clients they may also change, on request, their: • Mental health agency, or • Mental health care provider (care coordinator/ case manager/ therapist) And, when changes can be made: • In the first 90 days of a benefit • Once during each subsequent 12-month period • More frequently with documented justification provided by the client Respect the client's choice to make a change Ensure continuity of care during any transitions
File a request for an administrative fair hearing	Inform clients they may request a fair hearing if they: • Receive an adverse ruling by the RSN of a grievance or appeal • Feel a DSHS rule has been broken Provide information on: • Assistance available from the agency acting on a client's behalf, the Ombuds, King County Client Services, his/her representative or advocate, or if deceased a representative of his/her estate • Timelines for filing a request: ▪ Within 20 days of adverse ruling by RSN ▪ Any time a DSHS rule has been broken • How to request authorized services be continued during the grievance process Decisions are binding on the agency and RSN
Request and receive a copy of their medical records and ask for changes	Provide privacy for clients to read their chart • Explain things in the chart the client doesn't understand • Inform client if any portion of the record could not be released (harmful to the client or others) Incorporate changes requested by the client into the chart If the client requests copies, the fee is no more than 15 cents a page

Individual Rights – How to promote and protect each right	
Be free from retaliation	Ensure clients know: • They are free to exercise their rights without fear of retaliation • How to recognize retaliation if it happens, e.g.: ▪ Threatening to or actually terminating services ▪ Discouraging or depriving clients from exercising their rights ▪ Intimidating, threatening, or coercing the client in any way
Be informed that research concerning clients whose cost of care is publicly funded must be done in accordance with all applicable laws, including state rules on the protection of human research subjects	Inform clients if they are asked to participate in a research project: • They may refuse – participation is voluntary • If they refuse it will not impact their regular services • If they agree to participate: ▪ They will be asked to sign a consent that has information about the research ▪ They can stop their participation at any time ▪ Personal information will not be release without their consent except in emergencies
Discuss a concern with the Ombuds service, RSN, or provider if they believe their rights have been violated. If they discuss a concern or file a grievance or appeal, they must be free of any act of retaliation. The Ombuds may, at their request, assist them in resolving their concerns.	Make clients feel it's safe to express concerns that their rights may have been violated Provide client assistance in contacting: • Mental Health Ombuds • 206-205-5329 or 1-800-790-8049 #3 • King County Client Services • 206-263-8997 or 1-800-790-8049 Monitor that no retaliation occurs

Mental Health Advance Directives: What Clinicians Need to Know
King County Regional Support Network

Why clinicians need to know about mental health advance directives	• Clients have the right to have a mental health advance directive • Clinicians: ▪ Inform clients of this right when client rights are reviewed ▪ Are required by federal law to document whether or not a client has an advance directive ▪ Must provide written information to clients about mental health advance directives
What is an advance directive?	• An advance directive is a legal document that: ▪ Is created by the client at a time when he or she is capable of making treatment decisions in anticipation of a time when he or she is not able to do so. o A person is presumed "capable" unless formally determined NOT to be capable. ▪ Tells other people what his or her treatment choices are when he or she is unable to make those choices. • Advance directives exist for both physical health and mental health. • This information will focus on mental health advance directives in Washington State.
Washington State Law	• Engrossed Substitute Senate Bill 5223 ▪ Established guidelines for using Mental Health Advance Directives for adults in 2003 • Codified as Chapter 71.32 RCW • Purposes: ▪ Allows a person to get treatment if incapacitated and unable to provide consent o Early treatment may prevent the need for involuntary treatment ▪ Allows a person to express instructions and preferences to either consent to treatment or to refuse treatment
What are the potential benefits of an advance directive?	• Provides information about: ▪ What worked in the past ▪ Early symptoms and care alternatives that may reduce hospitalization • Empowers clients regarding treatment decisions • Can provide for a substitute decision-maker called an "agent" • Increased willingness of clients to seek voluntary treatment because they have more control over the process • Offers a vehicle to share information that normally would be unavailable to crisis/ emergency staff

Who would benefit from having an advance directive?	• Anyone a judge, mental health professional, or health care provider might decide is not capable of making decisions for his or her self • Anyone who might be: ▪ In crisis, and ▪ In a position in which he or she could not express his or her treatment preferences
Terminology used in an advance directive	• Principal ▪ The term used in statute to refer to the person executing a directive • Agent ▪ Also referred to as an attorney-in-fact, surrogate decision maker, or a proxy, and ▪ Named in a Durable Power of Attorney • Incapacitated ▪ Means a person cannot make sound decisions about his or her care or treatment ▪ Incapacity is determined by: o Superior Court (client or agent can request it) o One mental health professional and one health care provider* OR o Two health care providers* ▪ Client must be told that determination is being sought ▪ Client can challenge a determination of incapacity *One must be a psychiatrist, psychologist, or psychiatric ARNP
Key components of an advance directive	• Provides instructions about a person's treatment wishes, what a person: ▪ *Wants* in the way of treatment or services, and ▪ *Doesn't want* • Appointment of an "agent" ▪ When a person gives power to another individual to make decisions when he or she is incapacitated • The advance directive does not need to contain both of these components
Required elements of a valid Advance Directive	• Must be in writing • Contains language that the person intends to create a directive • Dated and signed by the person executing the directive • Designates whether or not the person wishes to be able to revoke his or her directive during incapacity • Was witnessed in writing by two adults who each: ▪ Personally know the person o Cannot be family members, treatment providers, or named Agent ▪ Was present when the directive was signed and dated by the person ▪ Can declare the person did not appear to be incapacitated or under duress

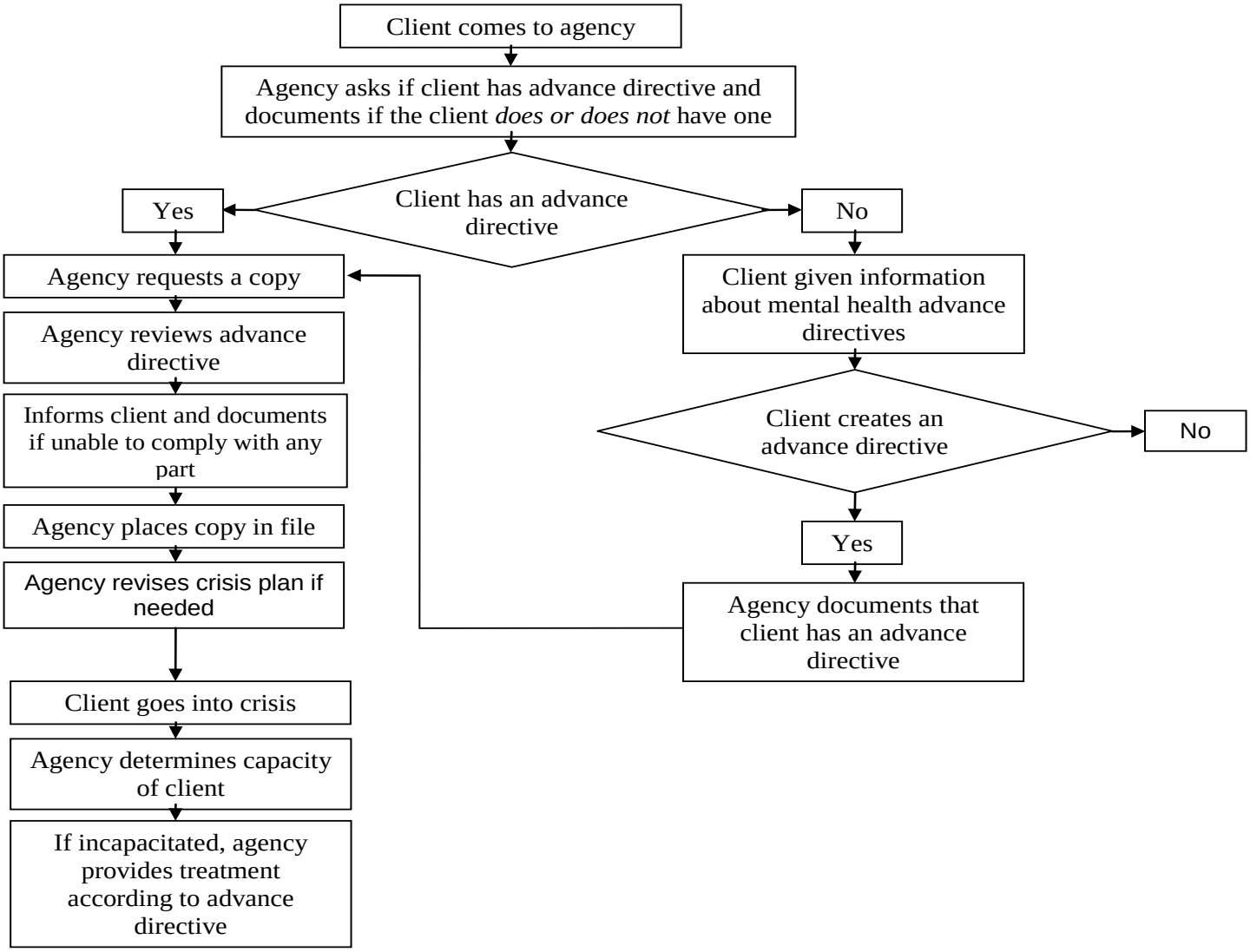
Provisions that can be included in an advance directive	• Preferences and instructions for mental health treatment • Consent to specific types of mental health treatment • Refusal to consent to specific types of mental health treatment • Consent for admission to and retention in a facility for mental health treatment for up to 14 days • Descriptions of situations that may cause the person to experience a mental health crisis • Instructions for care of children, pets, finances, and home • Suggested alternative responses that may supplement or be in lieu of direct mental health treatment ▪ Such as treatment approaches from other providers • Appointment of an agent to make mental health treatment decisions on the person's behalf ▪ Including authorizing the agent to provide consent on the person's behalf for voluntary admission to inpatient mental health treatment
Examples of instructions that may be in an advance directive	• Preferences for: ▪ Pre-emergency interventions ▪ Medications and treatments ▪ Handling emergency situations o e.g., use of restraints, seclusion, or tranquilization ▪ A specific hospital or alternatives to hospitalization • Consents to contact previous care providers • Identification of who: ▪ Should be notified if hospitalized ▪ May or may not come to visit in the hospital ▪ Should have access to mental health care records
Effective date, revocation, and expiration	• A directive is valid upon execution ▪ All or part of the directive may take effect at a later time as designated in the directive • A directive may be: ▪ Revoked, in whole or in part ▪ Time-limited (expiration date is identified in the directive), or have no expiration date
Revocation of a Directive	• A directive may be revoked by a person: ▪ With capacity o A person with capacity may revoke a directive in whole or in part. ▪ When incapacitated o An incapacitated person may revoke a directive only if he or she elected at the time of executing the directive to be able to revoke when incapacitated

Revocation of a Directive – continued	• The revocation: ▪ Must be in writing A copy must be given to: o The person's agent, if there is one o Any health care providers who already have a copy of the directive ▪ Is effective upon receipt by the agent and provider • A directive also may: ▪ Be revoked, in whole or in part, by a subsequent directive ▪ Be superseded or revoked by a court order, including any order entered in a criminal matter A directive may be superseded by a court order even if the order doesn't explicitly reference to the directive
Extension of expiration date	• Extension of date ▪ A directive that would have otherwise expired remains effective until the person is no longer incapacitated • No extension of date ▪ If the person has elected to be able to revoke while incapacitated and has revoked the directive.
Time frames for determination of incapacity	• Must occur within 48 hours of initial request for capacity determination • If client is hospitalized under the advance directive: ▪ Re-evaluate within 72 hours or upon change in condition and then as requested by client or agent • If client is in outpatient treatment: ▪ Re-evaluate within 5 days of the initial determination and then as requested by client or agent • Client is considered to have capacity if time frames are not met
Inpatient admission under an advance directive	• Client can be admitted as a voluntary patient for up to 14 days in any 21 day period • After 14 days (or less if specified in MHAD) the client must: ▪ Be referred to a Designated Mental Health Professional (DMHP), ▪ Remain as voluntary patient (can be encouraged to stay), or ▪ Be released during daylight hours • Client cannot be: ▪ Physically forced or restrained to prevent leaving if voluntary ▪ Retained in a hospital unless advance directive instructions are being substantially followed

Honoring advance directives	• Directives are not entitlements to care • But must be honored unless instructions: ▪ Conflict with involuntary treatment order ▪ Conflict with accepted standards of care ▪ Indicate treatment that is unavailable ▪ In an emergency, would endanger any person's life or health ▪ Indicate personal services (care of pets, household, finances) that facility doesn't normally provide ▪ Violate law • Clinicians are not subject to civil liability or sanctions for unprofessional conduct: ▪ If directives are honored in good faith and without negligence ▪ If directives cannot be honored and the client and agent are informed and reasons documented in chart • The inability to honor one section does not affect the validity of other sections
What clinicians should document	• Document if a client does or does not have an advance directive (for mental health or physical health) • Keep a copy of advance directives: ▪ In the client's record ▪ With the client's crisis plan • Note any revocation or changes in the client record • Upon receipt of the advance directive, if unable or unwilling to comply with any part or parts of the directive for any reason: ▪ Promptly notify the client and agent of the reason ▪ Document the reason in the client's record
Agents and what they can do	• Make decisions on behalf of the client: ▪ Consistent with the directive or otherwise known by the agent ▪ Based on the "best interest" of the client if instructions or preferences are not known • Receive, review, and authorize use and disclosure of medical records • Authority can be limited in the directive • May resign at any time by written notice to client and providers • Are not liable for cost of treatment • May not be paid • May not be the client's provider • Decisions are subordinate to decisions of a competent client
Other provisions	• If there is more than one directive, follow the directive most recently created • Directives validly executed in another jurisdiction are considered valid • Directives can be prepared and registered online at: ▪ http://www.doh.wa.gov/AboutUs/ProgramsandServices/DiseaseControlandHealthStatistics/CenterforHealthStatistics/LivingWillRegistry

Complaints about non-compliance with an advance directive	• Clients may make a complaint about a provider's non-compliance with an advance directive with: ▪ King County RSN Client Services o 206-263-8997 ▪ The Ombuds o 206-205-5329 ▪ The Washington State Department of Social and Health Services o 1-888-713-6010
What clinicians should do	• Understand the law • Develop and follow policies and procedures • Ask clients if they have an advance directive • If not, provide: ▪ Information about advance directives ▪ A copy of the DSHS brochure available in English and other languages at: o http://www.dshs.wa.gov/dbhr/advdirectives.shtml ▪ Assistance or referral to the state Office of Consumer Partnerships at 1-800-446-0259 for assistance to complete an advance directive • Keep documentation in client record • Integrate with treatment and crisis plans • Use and support the use of the advance directive once it's completed
Resources for clients and clinicians	• Washington State Department of Social and Health Services ▪ Brochure and Forms o http://www.dshs.wa.gov/dbhr/advdirectives.shtml ▪ Office of Consumer Partnerships o provides assistance in completing advance directives o 1-800-446-0259 ▪ Complaints about a provider's noncompliance with an advance directive o 1-888-713-6010 • Washington State Department of Health ▪ Online forms and electronic registration o http://www.doh.wa.gov/AboutUs/ProgramsandServices/DiseaseControlandHealthStatistics/CenterforHealthStatistics/LivingWillRegistry

Mental Health Advance Directives: Here's How They Work



DBHR Grievance System Reporting Instructions
July 31, 2013

These instructions for grievance and appeal reporting are specific directions in meeting grievance contract requirements. DBHR reviews of RSN policy and practices will use these guidelines.

Grievance and Appeal forms should be used as provided. The Notice of Action letter form is considered a template, and RSNs may use the included letter or make modifications that meet statutory requirements.

Administering the grievance system is a dynamic process that includes conversation between DBHR and the RSNs. Changes will be communicated to RSN administrators. For clarification on any issue, please contact your RSN contract manager.

I. GRIEVANCE SYSTEM OVERVIEW

Definitions

Individual: A person meeting the criteria for a consumer under WAC 388-865-0150, or a Medicaid enrollee. This definition includes a parent of a child under 13 who is receiving services, or a parent of a child under 18 who is involved with the treatment team. It does not include parents of adult children, other family members, or any other individual unless they are an authorized representative.

Authorized Representative: A person authorized by an individual to assist with the grievance, appeal, or Fair Hearing. Authorization should be in writing, but may be taken by phone if documented. Authorization may be as simple as: "____ has my permission to help me with my grievance."

Complaint: Any client expression of dissatisfaction that is resolved to the client's satisfaction through simple, first level dialog. A term no longer used by the Division of Behavioral Health and Recovery for reporting in the formal grievance system. Clients may complain about any issue of concern related to their mental health services, including access to such services. The term may also be used in referring to concerns a RSN or Ombuds investigates that fall outside the grievance system, such as concerns of a parent of an adult child, community members, or other system issues.

Grievance: An expression of dissatisfaction by an individual with RSN-related services that is not resolved to the client's satisfaction through simple, first level dialog. Grievances are formal processes that include requirements for letters of acknowledgement and resolution, as well as procedures for expediting grievances. The RSN is responsible for meeting grievance process requirements, but may delegate responsibilities to CMHAs by contract.

Individuals variously contact the RSN, Ombuds, or provider(s) regarding grievances. The grievance is then formally filed at either the provider (1st level) or RSN (2nd level), according to individual choice and RSN discretion.

Generally, grievances concern services provided by the RSN. Grievance definitions, however, are not specifically defined in law and fair hearings are sometimes filed over issues that do not involve direct services. In general, RSNs should accept grievances regarding any reasonable RSN-related issue.

Note: Filing grievances should be a common standard practice and not described to individuals in any way that discourages the process. It is expected that RSNs and CMHAs encourage and support using the grievance system.

1st Level Grievance: An expression of dissatisfaction with an RSN provider filed by an individual or their authorized representative at the provider level.

2nd Level Grievance: An expression of dissatisfaction with the RSN or an RSN provider that is filed by an individual at the RSN level, either as an initial grievance or filed as a result of dissatisfaction with a 1st level grievance. There is no required timeline for a person to file a second grievance with the RSN. A RSN may encourage grievances be initiated at the 1st level, but some grievances will be filed initially as 2nd level grievances at the RSN level, using discretion, due to individual choice or sensitive or extreme situations. The RSN should assist individuals with grievances, often by referral to the Ombuds or CMHA, with as much help provided as needed.

Appeal: A request to contest an RSN Notice of Action. An Action includes any decision by the RSN to deny, suspend, reduce, or terminate services, or a disagreement regarding the client's treatment plan. Key points:

1. A CMHA may not make decisions defined as Actions except under contracted delegation by the RSN.

2. All Actions are the responsibility of the RSN, although providing Notices of Action may be delegated to CMHAs. Notice of Action letters must include the RSN letterhead.

3. Any communication by a CMHA to an individual that the individual does not meet criteria for services (other than Medicaid eligibility) is an Action. A clinician might discuss criteria, but may not deny services without RSN authorization or delegated authority.

4. When services are ended during an authorization period without agreement by the individual, it is usually an Action and a Notice of Action letter must be provided.

    a. If services are ended because of missed appointments, without verification of agreement, this is generally a Termination. Whether it is an Action depends on the effect on the individual.

        i. If ending services limits or changes future services in any way, it is treated either as a suspension or termination. (Example: if an individual would be required to do another intake, it would be a termination).

        ii. If ending services is an administrative procedure and services will not be changed in any way when the individual re-engages, it is not an Action.

    b. Ending an authorization early without agreement is a termination.

    c. A CMHA is not allowed to impose any penalty or restriction on obtaining future services due to no shows or non-engagement with services. (Example: requiring a person to wait four weeks before rescheduling would not be allowed.)

d. It is expected that providers make all attempts to engage clients and to fully document the reasons for ending services. Sending a written letter to re-engage clients is recommended before taking an Action.

5. A medication decision by a provider without an individual's agreement is an Action, either a denial or disagreement with the treatment plan.

6. Actions include instances where an individual disagrees with a treatment plan (chooses not to sign the plan because of disagreement or at any time clearly states disagreement). Disagreement may include requests for types of treatment the clinician does not see as medically necessary.

7. Denial of any requested service, even a non-covered service, is an Action.

8. When a particular level of service (such as requests for intensive children's services) is denied, it is an Action, even if the individual is authorized for other services. If an individual or parent agrees with the decision, it is not an Action.

9. A person who is not eligible for services because they are not Medicaid enrolled does not receive a Notice of Action and may not file a grievance.

Second Opinions: It is often good practice to recommend obtaining a second opinion on any matter before taking an Action such as a denial. If the RSN does makes a denial decision or other Action, a Notice of Action is issued, even though an individual may still request a second opinion from the provider before filing an appeal. Second opinions may also be requested for medication issues.

Other Quality Issues: All RSNs respond to and investigate issues and concerns falling outside the formal grievance system. As part of an overall Quality Assurance program, each RSN tracks these system issues in a way that meets their needs for evaluating services. (Example: a RSN may track and trend complaints from community members, stakeholders and family members, although these issues are not reported to DBHR as grievances.) Note that Ombuds may also investigate issues other than formal grievances freely.

Fair Hearing: An individual may not request a Fair Hearing regarding an RSN Action without first filing an RSN appeal. An individual may, however, request a Fair Hearing regarding dissatisfaction issues without first filing a grievance. An individual may request a hearing with the Office of Administrative Hearings if they believe a law has been broken, or legal time frames were not kept.

II. GRIEVANCE, NOTICE OF ACTION, AND APPEAL REPORT INSTRUCTIONS

Reporting Periods

1. April through September, due November 15

2. October through March, due May 15

The Grievance System

Although other information regarding system issues is collected by RSNs as part of an overall Quality Assurance program, the grievance system refers to specific information reportable to DBHR. The information reported to DBHR includes:

1. 1st level grievances
2. 2nd level grievances
3. Notices of Action
4. Notice of Action appeals
5. Fair Hearings
6. Ombuds cases

RSNs are responsible for ensuring all timelines are kept, and clients informed of all rights. If processes are delegated to CMHAs, RSNs are responsible for appropriate training.

Timelines and Other

1. Grievance timelines begin when the individual, representative, or Ombuds reports a grievance to the provider or RSN.
2. Acknowledgment letters and resolution letters may be sent by either the provider or the RSN, with the RSN responsible for oversight. Grievance letters may not be sent by the Ombuds.
3. If the individual disagrees with a 1st level (CMHA) grievance resolution, the CMHA sends a letter of resolution with their decision. The individual may then choose to continue the issue by filing a 2nd level grievance at the RSN. 2nd level grievances also result in a letter of resolution. Decisions at each level are documented.
4. Medicaid vs. State-Only Grievance: The type of grievance is determined by the funding source. Medicaid billable services are Medicaid grievances, which is the largest category. A service paid for with RSN state dollars, however, such as food at an E&T is recorded as a State-Only Grievance.
5. A grievance must be resolved within 90 days or as expeditiously as needed, per CFR. A Level 1 and Level 2 grievance each have a 90-day timeline, even if they regard the same person.
6. There is no set time limit for filing a grievance.

Grievance Report Instructions:

1. Reporting a grievance: A grievance may include more than one category, such as Dignity and Respect and Phone Calls Not Returned.

2. The box at the top of the form is a total all unduplicated individual grievances. If one individual files both a Level 1 and a Level 2 grievance, it is counted as two grievances. The RSN ensures that the same grievance is not counted by different CMHAs or by both the CMHA and RSN.

3. A grievance filed by an individual against separate CMHAs is counted as separate grievances. In rare instances, the RSN may treat these grievances as one Level 2 grievance, listing each issue in acknowledgement and resolution letters. The resolution of each issue must be documented.

4. Grievances are reported only in the period in which they were first filed. Resolutions of pending grievances are tallied in the period in which they are resolved.

5. At times, an individual filing a grievance may add concerns during the process of a grievance, although a grievance may need a resolution at some point to meet timeframes. This decision should be made with caution and documented, as the additional issue would not be in the acknowledgement letter. The agency may also send an additional acknowledgment letter. In these cases, a new grievance would only be filed after resolution of current issues.

Example 1: After explaining their grievance about a case manager, a few days later the individual adds that the receptionist was disrespectful. These could be investigated and resolved together as the same grievance.

Example 2: An individual begins a grievance with multiple issues and continues to add issues throughout the process. The RSN at one point would end one grievance with multiple issues and begin a second grievance with newer issues.

Deciding to combine several issues into a single grievance is made using professional judgment.

Notice of Action Instructions:

Note: It can often be effective to recommend a second opinion before making an RSN decision.

1. The RSN must ensure that all individuals are provided with a Notice of Action for any denial, termination, suspension, reduction, or disagreement with the treatment plan.

2. Notices of Action may be prepared by either the RSN or a delegated CMHA. An Ombuds may not issue a Notice of Action. The Ombuds may notify the RSN or provider that a Notice of Action needs to be provided.

3. A Notice of Action provided by a CMHA must use the RSN letterhead.

The RSN must ensure that delegated Notices of Actions include all required elements and rights.

Appeal Report Instructions:

1. All appeals are filed only at the RSN, regardless of where the Notice of Action is issued.

2. There is no need for an unduplicated Ombuds count. The Ombuds column total is informational, to determine overall Ombuds involvement.

III. GRIEVANCE REPORT CATEGORIES

Important Note: Medicaid enrollees have rights to receive a Notice of Action and to file an appeal for some service issues. It is important to ensure Medicaid enrollees receive a Notice of Action in these cases and that they are directed to file appeals, not grievances. A non-Medicaid individual, however, may file a grievance over any RSN decision or service issue—these are reported on the State-only grievance form.

Access:

1. Concerns about ability to receive intake appointments, timeliness of referrals and appointments, or other issues with the intake or referral process

2. Inability to access services due to language barriers

3. Denials, terminations, suspensions, or reductions of services for Non-Medicaid clients.

(A denial or termination of services for a Medicaid client is not a grievance, it is an Action, and the RSN must provide a Notice of Action. Notices of Actions may then be appealed.)

Dignity and Respect: Issues regarding courtesy, tone of voice, language, or other treatment seen as disrespectful

Quality/Appropriateness: Issues regarding poor quality treatment or treatment errors.

Phone Calls Not Returned: May involve calls made to multiple clinicians or supervisors.

Service Intensity, Not available or Coordination of Services: Generally issues in this category would be Actions (disagreement with treatment plan), except for Non-Medicaid clients. May include problems with coordination between providers, peer support services, health care providers or others involved in the treatment plan.

Participation in Treatment: A grievance might be an individual's voice and viewpoint is not being included in treatment planning, or a parent is dissatisfied with their level of participation or requested other supports are not involved in treatment planning.

Physicians, ARNPs, and Medications: Problems with communication or scheduling issues. Disagreement with medications is an Action for Medicaid clients and requires providing a Notice of Action. A person may also request a second opinion.

Financial and Administrative Services: Generally deals with payees employed by the CMHA and funded by the RSN, or incorrect paperwork or billing issues. An individual may not file a grievance regarding eligibility for SSI or regarding private payees.

Residential: Any issue with RSN-related services. These should primarily concern mental health treatment activities, noise, or privacy. An individual may, however, file a grievance with other issues including food, health, or safety. These issues should be investigated by the RSN as well as be referred to the Department of Health.

Housing: Issues related to effectiveness in assisting clients to obtain and maintain housing. This does not include Landlord/Tenant issues.

Transportation: Issues relating to transportation that are RSN-related.

Emergency Services: These grievances would always involve an additional category, to clarify the nature of the problem. Grievances generally relate to services the RSN provides, including crisis lines, E&T centers, hospital alternative programs, or detainments.

A person may file a RSN grievance about a DMHP or detention services. The result of the detention process is under the jurisdiction of a Superior Court and is not grievable. RSNs should note any trends in detentions. Examples of grievances might be dignity and respect issues, privacy, lack of timeliness, or lack of due process.

Grievances from RSN-enrolled clients regarding an authorized stay in a community hospital are also accepted, as well as encouraging clients to use hospital-specific complaint processes. The intention is to maintain dialogue with hospitals to ensure quality service for RSN clients.

Violation of Confidentiality: Any information regarding a client that is inappropriately disclosed, including name, diagnosis, treatment, or providers.

Other Rights Violations: Violation of any consumer rights that are not covered in other categories (such as dignity and respect and confidentiality). These could include issues involving interpreters, cultural differences, or Advance Directives.

Other: A rarely used category for hard to categorize issues.

Resolution Types

Information or Referral: A grievance is resolved mutually through providing additional information or referral to other services. An example would be a person believing their rights had been violated but was satisfied by being directed to WAC.

Conciliation/Mediation: A resolution agreed to mutually.

Not Pursued: Client requested to end grievance, discontinued participation in grievance process, moved away, was hospitalized, died, etc. A letter of resolution should be sent whenever possible, using discretion and sensitivity.

Other: An RSN resolution decision without mutual agreement. Other hard to categorize resolutions.

(A Fair Hearing is not a resolution. The grievance resolution letter is sent with its explanation—that is the resolution. The filing of a Fair Hearing is a separate decision.)

RSN Grievance Report-- Medicaid Funded Services

Reporting Period _____

RSN Name _____ **Contact Name:** _____ **Contact Number:** _____

Total Unduplicated Number of Adult Grievances _____

Total Unduplicated Number of Children's Grievances _____

Category Adult (21 Yrs. and over)	Level 1 Grievances	Level 2 Grievances	Outstanding	Fair Hearings Filed
Access				
Dignity and Respect				
Quality/ Appropriateness				
Phone calls not returned				
Service – Intensity, Not Available, Coordination				
Violation of Confidentiality				
Physicians and ARNPs				
Financial & Admin Svs				
Residential				
Housing				
Transportation				
Emergency Services				
Participation in Treatment				
Other Rights Violations				
Other				
Total	0	0	0	0

Category Children (0-20 Yrs.)	Level 1 Grievances	Level 2 Grievances	Outstanding	Fair Hearings Filed
Access				
Dignity and Respect				
Quality/ Appropriateness				
Phone calls not returned				
Service -- Intensity, Not Available, Coordination				
Violation of Confidentiality				
Physicians and ARNPs				
Financial & Admin Svs				
Residential				
Housing				
Transportation				
Emergency Services				
Participation in Treatment				
Other Rights Violations				
Other				
Total	0	0	0	0

Resolutions Adult (21 Yrs. and over)	Level 1 Grievances	Level 2 Grievances	Outstanding from Last Period
Information/Referral			
Conciliation/Mediation			
Not Pursued			
Other			
Total	0	0	0

Resolutions Children (0-20 Yrs.)	Level 1 Grievances	Level 2 Grievances	Outstanding from Last Period
Information/Referral			
Conciliation/Mediation			
Not Pursued			
Other			
Total	0	0	0

Ombuds Cases	
Level 1 Grievances	Level 2 Grievances

RSN Grievance Report-- State Funded Services Only

Reporting Period _____

RSN Name _____ **Contact Name:** _____ **Contact Number:** _____

Total Unduplicated Number of Adult Grievances _____

Total Unduplicated Number of Children's Grievances _____

Category Adult (21 Yrs. and over)	Level 1 Grievances	Level 2 Grievances	Outstanding	Fair Hearings Filed
Access				
Dignity and Respect				
Quality/ Appropriateness				
Phone calls not returned				
Service – Intensity, Not Available, Coordination				
Participation in Treatment				
Physicians and ARNPs				
Financial & Admin Svs				
Residential				
Housing				
Transportation				
Emergency Services				
Violation of Confidentiality				
Other Rights Violations				
Other				
Total	**0**	**0**	**0**	**0**

Category Children (0-20 Yrs.)	Level 1 Grievances	Level 2 Grievances	Outstanding	Fair Hearings Filed
Access				
Dignity and Respect				
Quality/ Appropriateness				
Phone calls not returned				
Service -- Intensity, Not Available, Coordination				
Participation in Treatment				
Physicians and ARNPs				
Financial & Admin Svs				
Residential				
Housing				
Transportation				
Emergency Services				
Violation of Confidentiality				
Other Rights Violations				
Other				
Total	**0**	**0**	**0**	**0**

Resolutions Adult (21 Yrs. and over)	Level 1 Grievances	Level 2 Grievances	Outstanding from Last Period
Info/Referral			
Conciliation/Mediation			
Not Pursued			
Other			
Total	**0**	**0**	**0**

Resolutions Children (0-20 Yrs.)	Level 1 Grievances	Level 2 Grievances	Outstanding from Last Period
Info/Referral			
Conciliation/Mediation			
Not Pursued			
Other			
Total	**0**	**0**	**0**

Ombuds Cases	
Level 1 Grievances	Level 2 Grievances

GRIEVANCE PROCEDURE PROVIDER TRACKING FORM

1. Client Name: _____

2. King County ID Number: _____

3. Agency ID Number: _____

4. Date of Receipt of oral grievance: (if filed orally)_____

   May come to the provider directly from the client or via the Ombuds service or the KCMHP Client Services. If the grievance was received on a non-business day, enter the date of the next business day.

5. Date client provides written, signed documentation of a grievance request filed orally: _____

   Must be within seven calendar days of date of receipt for grievance to continue.

6. Date of receipt of written grievance: _____

   May come to the provider directly from the client or via the Ombuds service or the KCMHP Client Services. If the grievance was received on a non-business day, enter the date of the next business day.

7. Date provider acknowledges to client that the grievance has been received: _____

   Must be within one business day of date of receipt. If the client filed the grievance orally, he/she must be both phoned and mailed an acknowledgement. A grievance filed in writing only requires a written acknowledgement only. The written acknowledgement must meet the requirements of 10.4.4.B.

8. Date provider sends fax to KCMHP Client Services to inform of grievance: _____

   Must be within one business day of date of receipt and must specify the date of receipt. This step is omitted if the provider was forwarded the grievance by KCMHP Client Services.

9. Date client ***and KCMHP*** receive written grievance resolution: _____

   Must be within 30 calendar days of date of receipt or more expeditiously if the client's mental health condition requires it.
   If this does not occur, please provide the client's address, so that KCMHP can send the client a Notice of Action:

   _____
   _____
   _____

   ***Note**: When grievance is completed (or is no longer being pursued), this form should be kept in grievance records at provider agency and a copy should be **faxed** to KCMHP Client Services at 206-205-1634.*

NOTICE OF DETERMINATION ABOUT YOUR MENTAL HEALTH SERVICES

This letter is to let you know that as of you have been authorized to mental health services at , a mental health agency under contract with the King County Mental Health Plan (KCMHP).

Services will be provided until , and may be authorized for one or more additional year(s), as long as:

- Services are medically necessary.
- You live in King County.
- If you have Medicaid, your Medicaid has not ended.

We hope you will find this care helpful.

You do not need to reply to this notice. If you have questions, please contact the person you are seeing for mental health services or KCMHP Client Services at 1-800-790-8049.

NOTICE OF ACTION ABOUT YOUR MENTAL HEALTH SERVICES

Date:

To:

King County

From: Client Services
King County Mental Health Plan
The Chinook Building
401 Fifth Avenue, Suite 400
Seattle, WA 98104-2333

This is to let you know about an action that has occurred concerning your mental health services that you are currently receiving at .

Action:

☐ Enrollee Disagreement with all or part of the Treatment Plan

Effective Date

The reason for this action is:

☐ Your treatment provider has informed us, which they are required to do, that you disagree with all or part of your treatment plan for authorized covered Medicaid mental health services.

Contact person (and telephone number) concerning this Notice: Client Services, 1-800-790-8049

BECAUSE YOU DISAGREE WITH YOUR TREATMENT PLAN

1. **You are entitled to a second opinion.** You may tell the person you saw at the mental health agency that you would like another evaluation by a different person and one will be arranged for you.
2. **You have the right to appeal**. If you choose this right, you have forty-five[1] (45) calendar days from the date this notice was mailed to request or file an appeal. Your mental health provider may also file an appeal on your behalf when you ask them in writing. To request or file an appeal, you need to contact: KCMHP Client Services by calling 1-800-790-8049 or send your appeal to the address above or by fax to 206-205-1634.

   If you need help with filing an appeal you may contact the KCMHP Ombuds Service at 1-800-790-8049. The Ombuds Service is available at no charge to assist you or your representative throughout the appeal process. If you are hard of hearing or deaf, or have trouble with speech, please contact us through the Telecommunication Relay Service at 1-800-833-6384 or dial 711. The Relay Service will be able to provide you with the correct phone number. If you need interpreter services they will be provided to you.

   You may also have other persons of your choice assist you during the appeal process. If you want someone else to assist you, you and your authorized representative must sign, date and send us a statement naming that person to act for you.

   Before you file an appeal, please see, "<u>Important Information About Your Appeal Rights</u>" on the next page

[1] If you want to continue to receive your current services during the appeal process, you must file your request within ten (10) calendar days of the receipt of this notice of action.

Important Information About Your Appeal Rights

Definitions

Disagreement on Treatment Plan: An Enrollee's disagreement with the treatment plan for authorized covered Medicaid mental health services as discussed with their treatment provider.

There Are Two Kinds of Appeals You Can File

Standard (45 days) You or your mental health care provider acting on your behalf can ask for a standard appeal. We must give you a decision no later than 45 days after we get your appeal. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)

Expedited (Fast,3 working days) You or your mental health care provider can ask for a fast appeal if you or your mental health care provider believe that your life, health or major ability to function could be seriously harmed by waiting for a standard appeal. We must decide your appeal no later than 3 working days after we get your appeal. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)

- If your mental health care provider asks for an expedited appeal for you, or supports you in asking for one, and they indicate that waiting 45 days could seriously harm your health, we will automatically give you a fast appeal.
- If you ask for an expedited appeal without support from your mental health care provider, we will decide if your health requires one. If we do not agree with you, we will decide your appeal within 45 days.

How Do I File An Appeal?

For a Standard Appeal: You, your mental health provider, authorized representative, or an Ombuds should mail or deliver your written appeal to the address below. You may file verbally but, it must be followed in writing.

For a Fast Appeal: You, your mental health provider, authorized representative, or an Ombuds should contact us by telephone or fax at the numbers listed below.

Can I Continue to Receive Services?
If you are currently receiving services, your services will be continued during the appeal process when:

- Your appeal is filed within 10 days from KCMHP mailed date.
- Your appeal involves a disagreement with your treatment plan for authorized covered Medicaid mental health services;
- The current period covered by the authorization has not expired, and the Notice of Action was mailed to you timely
- You have requested an extension.

If our decision is not your favor, you may be asked to pay for the services you received during the appeal or hearing.

What Do I Include With My Appeal?

You should include: your name, address, reasons for appealing, and any evidence you wish to attach. You may send in supporting records, letters from your mental health provider, a list identifying qualified witnesses, or other information that explains why we should provide the service. Call your mental health provider if you need this information to help you with your appeal.

You may send this information to KCMHP or present this information in person.

What Happens After I File An Appeal? People from KCMHP who were not involved in the decision review your appeal and provides a written decision within 45 days unless an extension has been requested.

What Happens Next? After KCMHP makes a decision about your appeal and you do not agree with the KCMHP decision, you may ask for a fair hearing through the State Office of Administrative Hearings (1-800-583-8271). You must request a fair hearing within 20 days after you receive the KCMHP decision. You may also access a fair hearing if:

- KCMHP does not provide a written response within the allowed time frames; or
- You believe there has been a violation of WA State Department of Social and Health Services rules.

Your services may be continued during the Administrative Hearing Process.

Contact Information: If you need information or help, call us at:

Client Services
King County Mental Health Plan (KCMHP)
The Chinook Building
401 Fifth Avenue, Suite 400
Seattle, WA 98104-2333
Telephone: 1-800-790-8049 or Fax: 206-205-1634

Hearing or Speech Impaired, please contact us via:
Telecommunication Relay Service at
1-800-833-6384 or dial 711

Other Resources to Help You:

King County Mental Health Plan Ombuds Service
Telephone: 1-800-790-8049 or Fax: 206-296-1438

WA State Department of Social and Health Services Office of Administrative Hearings
P. O. Box 42488
Olympia, WA 98504-2488
1-800-583-8271

NOTICE OF DETERMINATION ABOUT YOUR MENTAL HEALTH SERVICES

Date:

King County

To:

From: Client Services
King County Mental Health Plan
The Chinook Building
401 Fifth Avenue, Suite 400
Seattle, WA 98104-2333

This is to let you know about a decision concerning your publicly funded mental health services that you requested or are currently receiving.

KCMHP has determined that your Mental Health Services will be:

- ☐ DENIED Effective Date
- ☐ REDUCED To From
  Effective Date
- ☐ SUSPENDED Effective Date
- ☐ TERMINATED Effective Date

The reason for this decision is:

- ☐ You do not meet medical necessity criteria.
- ☐ You are no longer a King County resident.
- ☐ KCMHP has insufficient funds to provide the requested services.
- ☐ You are no longer covered under Medicaid and KCMHP has insufficient funds to provide additional services.
- ☐ Other:

Contact person (and telephone number) concerning this Notice: Client Services, 1-800-790-8049

IF YOU DON'T AGREE WITH THIS DECISION:

1. **You may request a second opinion if <u>all</u> of the following have occurred:** a) the "denied" box is checked above, b) the box that states "you do not meet medical necessity criteria" is checked above, and c) in the last 30 days you were discharged or released from any of the following facilities: Western State Hospital, Child Study and Treatment Center, McGraw Center, Pearl Street Center, Tamarack Center, or a Washington State prison or juvenile rehabilitation facility. To make this request contact KCMHP Client Services by calling 1-800-790-8049.

2. **You have the right to file a grievance.**

   a. If you choose this right, you have twenty (20) calendar days from the date this notice was mailed to request or file a grievance. If, however, your grievance is about previously authorized services and you wish them to continue, you must instead request or file the grievance within ten (10) calendar days from the date this notice was mailed to you. Your mental health provider may also file a grievance on your behalf when you ask them in writing. To request or file a grievance, you need to contact: KCMHP Client Services by calling 1-800-790-8049 or send your grievance to the address above or by fax to 206-205-1634.

   b. **If you need help with filing a grievance** you may contact the KCMHP Ombuds Service at 1-800-790-8049. The Ombuds Service is available at no charge to assist you or your representative throughout the grievance process. If you are hard of hearing or deaf, or have trouble with speech, please contact us through the Telecommunication Relay Service at 1-800-833-6384 or dial 711. The Relay Service will be able to provide you with the correct phone number. If you need interpreter services they will be provided to you.

   c. You may also have other persons of your choice assist you during the grievance process. If you want someone else to assist you, you and your authorized representative must sign, date and send us a statement naming that person to act for you.

Before you file a grievance, please see "<u>Important Information About Your Grievance Rights</u>" on the next page

Important Information About Your Grievance Rights

Definitions

Denial: The decision by the KCMHP to not authorize a covered mental health service that has been requested by a provider on behalf of a client.

Suspension: The decision by the KCMHP to temporarily stop your previously authorized covered mental health services described in its Level of Care Guidelines. The clinical decision by a Community Mental Health Agency to temporarily stop or change a covered service in the Individual Service Plan is not a suspension.

Reduction: The decision by the KCMHP to decrease an your previously authorized covered mental health services described in its Level of Care Guidelines. The clinical decision by a Community Mental Health Agency to decrease or change a covered service in the Individual Service Plan is not a reduction.

Termination: The decision by the KCMHP to stop your previously authorized covered Medicaid mental health services described in its Level of Care Guidelines. The clinical decision by a Community Mental Health Agency to stop or change a covered service in the Individual Service Plan is not a termination.

How Do I File A Grievance?
You, your authorized representative, or an Ombuds should mail or deliver your written grievance to the address below. You may file verbally but, it must be followed in writing within seven calendar days.

Can I Continue to Receive Services? If you are currently receiving services, your services will be continued during the grievance process when:

- Your grievance is filed on time;
- Your grievance involves the reduction, suspension or termination of previously authorized mental health services;
- You have requested an extension.

If our decision is not your favor, you may be asked to pay for the services you received during the grievance or hearing.

What Do I Include With My Grievance?
You should include:

- Your name
- Address
- Reasons for filing a grievance
- Any evidence you wish to attach

You may send in supporting records, letters from your mental health provider, a list identifying qualified witnesses, or other information that explains why we should provide the service. Call your mental health provider if you need this information to help you with your grievance.

You may send this information to KCMHP or present this information in person.

What Happens After I File A Grievance? People from KCMHP who were not involved in the decision review your grievance and provide a written decision within 30 days unless an extension has been requested. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)

What Happens Next? After KCMHP makes a decision about your grievance and you do not agree with the KCMHP decision, you may ask for a fair hearing through the State Office of Administrative Hearings (1-800-583-8271). You must request a fair hearing within 20 days after you receive the KCMHP decision. You may also access a fair hearing if:

- KCMHP does not provide a written response within the allowed time frames; or
- You believe there has been a violation of WA State Department of Social and Health Services rules.

Contact Information: If you need information or help, call us at:

Client Services
King County Mental Health Plan (KCMHP)
The Chinook building
401 Fifth Avenue, Suite 400
Seattle, WA 98104-2333
Telephone: 1-800-790-8049 or Fax: 206-205-1634

Hearing or Speech Impaired, please contact us via:
Telecommunication Relay Service at
1-800-833-6384 or dial 711

Other Resources to Help You:

King County Mental Health Plan Ombuds Service
Telephone: 1-800-790-8049 or Fax: 206-296-1438

WA State Department of Social and Health Services Office of Administrative Hearings
P. O. Box 42488
Olympia, WA 98504-2488
1-800-583-8271

Alternate Formats Available Upon Request

NOTICE OF ACTION ABOUT YOUR MENTAL HEALTH SERVICES

Date:

To:

From: Client Services
King County Mental Health Plan
The Chinook Building
401 Fifth Avenue, Suite 400
Seattle, WA 98104-2333

This is to let you know about an action we are planning to take concerning your mental health services that you requested or are currently receiving at .

We have decided that your mental health services will be:

- ☐ **DENIED** Effective Date
- ☐ **REDUCED** To From
  Effective Date
- ☐ **SUSPENDED** Effective Date
- ☐ **TERMINATED** Effective Date

The reason for this decision is:

- ☐ You are no longer a King County resident.
- ☐ You do not meet medical necessity criteria.
- ☐ Other:

Contact person (and telephone number) concerning this Notice: Client Services, 1-800-790-8049

IF YOU DON'T AGREE WITH THIS DECISION

1. **You are entitled to a second opinion.** You may tell the person you saw at the mental health agency that you would like another evaluation by a different person and one will be arranged for you.
2. **You have the right to appeal**. If you choose this right, you have twenty[1] (20) calendar days from the date this notice was mailed to request or file an appeal. Your mental health provider may also file an appeal on your behalf when you ask them in writing. To request or file an appeal, you need to contact: KCMHP Client Services by calling 1-800-790-8049 or send your appeal to the address above or by fax to 206-205-1634.

   If you need help with filing an appeal you may contact the KCMHP Ombuds Service at 1-800-790-8049. The Ombuds Service is available at no charge to assist you or your representative throughout the appeal process. If you are hard of hearing or deaf, or have trouble with speech, please contact us through the Telecommunication Relay Service at 1-800-833-6384 or dial 711. The Relay Service will be able to provide you with the correct phone number. If you need interpreter services they will be provided to you.

   You may also have other persons of your choice assist you during the appeal process. If you want someone else to assist you, you and your authorized representative must sign, date and send us a statement naming that person to act for you.

Before you file an appeal, please see "Important Information About Your Appeal Rights" on the next page.

Alternate Formats Available Upon Request

[1] If you want to continue to receive your current services during the appeal process, you must file your request within ten (10) calendar days of the receipt of this notice of action.

Important Information About Your Appeal Rights

Definitions

Denial: The decision not to offer an intake is a denial. The decision by a PIHP, or their formal designee, not to authorize covered Medicaid mental health services that meet medical necessity is a denial.

Suspension: The decision by a PIHP, or their formal designee, to temporarily stop your previously authorized covered Medicaid mental health services described in their Level of Care Guidelines. The clinical decision by a Community Mental Health Agency to temporarily stop or change a covered service in the Individual Service Plan is not a suspension.

Reduction: The decision by a PIHP to decrease an your previously authorized covered Medicaid mental health services described in their Level of Care Guidelines. The decision clinical by a Community Mental Health Agency to decrease or change a covered service in the Individual Service Plan is not a reduction.

Termination: The decision by a PIHP, or their formal designee, to stop your previously authorized covered Medicaid mental health services described in their Level of Care Guidelines. The clinical decision by a Community Mental Health Agency to stop or change a covered service in the Individual Service Plan is not a termination.

There Are Two Kinds of Appeals You Can File

Standard (45 days) You or your mental health care provider acting on your behalf can ask for a standard appeal. We must give you a decision no later than 45 days after we get your appeal. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)

Expedited (Fast, 3 working days) You or your mental health care provider can ask for a fast appeal if you or your mental health care provider believe that your life, health or major ability to function could be seriously harmed by waiting for a standard appeal. We must decide your appeal no later than 3 working days after we get your appeal. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)

- If your mental health care provider asks for an expedited appeal for you, or supports you in asking for one, and they indicate that waiting 45 days could seriously harm your health, we will automatically give you a fast appeal.
- If you ask for an expedited appeal without support from your mental health care provider, we will decide if your health requires one. If we do not agree with you, we will decide your appeal within 45 days.

How Do I File An Appeal?

For a Standard Appeal: You, your mental health provider, authorized representative, or an Ombuds should mail or deliver your written appeal to the address below. You may file verbally but, it must be followed in writing.

For a Fast Appeal: You, your mental health provider, authorized representative, or an Ombuds should contact us by telephone or fax at the numbers listed below.

Can I Continue to Receive Services?

If you are currently receiving services, your services will be continued during the appeal process when:

- Your appeal is filed within 10 days from KCMHP mailed date.
- Your appeal involves the reduction, suspension or termination of previously authorized covered Medicaid mental health services;
- The current period covered by the authorization has not expired, and the Notice of Action was mailed to you timely
- You have requested an extension.

If our decision is not your favor, you may be asked to pay for the services you received during the appeal or hearing.

What Do I Include With My Appeal?

You should include: your name, address, reasons for appealing, and any evidence you wish to attach. You may send in supporting records, letters from your mental health provider, a list identifying qualified witnesses, or other information that explains why we should provide the service. Call your mental health provider if you need this information to help you with your appeal.

You may send this information to KCMHP or present this information in person.

What Happens After I File An Appeal? People from KCMHP who were not involved in the decision review your appeal and provides a written decision within 45 days unless an extension has been requested.

What Happens Next? After KCMHP makes a decision about your appeal and you do not agree with the KCMHP decision, you may ask for a fair hearing through the State Office of Administrative Hearings (1-800-583-8271). You must request a fair hearing within 20 days after you receive the KCMHP decision. You may also access a fair hearing if:

- KCMHP does not provide a written response within the allowed time frames; or
- You believe there has been a violation of WA State Department of Social and Health Services rules.

Your services may be continued during the Administrative Hearing Process.

Contact Information: If you need information or help, call us at:

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WA State Department of Social and Health Services Office of Administrative Hearings
P. O. Box 42488
Olympia, WA 98504-2488
1-800-583-8271

ACCESSING MEDICAL CARE

How can I access medical care that is covered by Medicaid?

Your ProviderOne ID or Apple Health ID card will have information on it that shows what kind of plan you have; either Managed Care or Fee for Service.

- **Managed Care:** If you are enrolled in managed care under Washington Apple Health, you can call one of the plans listed directly below and request care.

  The following medical plans provide Managed Care to those who receive Medicaid:

Plan Name	Toll-Free Numbers
Amerigroup Washington, Inc.	1-800-600-4441
Community Health Plan of WA	1-800-440-1561
Coordinated Care Corporation	1-877-644-4613
Molina Healthcare of Washington, Inc.	1-800-869-7165
United Health Care Community Plan	1-877-542-8997

  If you need more help or information, you can:

  - Go to the Washington Apple Health website: http://www.wahealthplanfinder.org; or
  - Call 1-855-923-4633 and speak to someone about the medical plans available in your community.

- **Fee for Service (FFS).** If you are Medicaid FFS, you can go to any doctor who is contracted with the Health Care Authority (HCA). Contact the doctor to see if they are a Medicaid provider before making an appointment.

  To find a doctor or clinic in your area, you may:

  - Call this toll-free number: 1-800-562-3022.
  - Go to the website: http://www.hca.wa.gov/medicaid/Pages/index.aspx

EPSDT RIGHTS FOR CHILDREN

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a health program for children with Medicaid coverage, including foster children. With EPSDT, children can get a regular checkup. If your child needs to get medical care for a problem that is found during the checkup, Medicaid will also pay for the follow-up care. Every child birth and up to 21 years of age has Medicaid coverage to get regular health checkups.

- **When should children get a checkup?**

  Children should receive their first exam soon after the child is eligible for Medicaid. After the first exam, Children 2 to 6 years old should get a checkup once a year. Children ages 7 through 20 should get a check up every other year. For children under age 2, consult with your primary care provider about how often to get a check up. Medicaid will also cover a dental checkup for children twice a year.

- **What if I need transportation for medical care?**

  In many cases, Medicaid will pay for transportation to health related services. If you need help finding transportation call this toll-free number:

  1-800-562-3022

- **What if my child or I need a Dentist?**

  Limited dental coverage is available to Medicaid enrollees. To find a dentist, call the local dental society in your area. It will be listed in your yellow pages under “Dentist Referral” or call the number above.

Alternate Formats Available Upon Request

When to Send a Notice of Determination or Notice of Action

In accordance with state Mental Health Division contract requirements

Notices of Determination cannot be delegated to a subcontracted network CMHA, however, the CMHA may deliver the notification. Notices of Actions must be mailed by KCMHP per contract and Code of Federal Regulations (CFR).

P&P Attachment	Determination	**Notice of Determination** *Notice Must be Delivered within 14 Days of Authorization Decision*		**Notice of Action** *Notice Sent per CFR Time Frames*
		Non-Medicaid	Medicaid	Medicaid
C	Services Authorized -- For programs: 2X1 (Outpatient 2X), 3A1 (Outpatient 3A), 3B1 (Outpatient 3B), 65 (ECS Expanded), 66 (ECS/ ICSRP), 71 (LTR), 372 (ISH), 373 (SSH)	X	X	
F & I	Intake Denied by CMHA -- For Medicaid or First Priority Non-Medicaid clients--see P&P Attachment I	X		X[1,3,4]
Lack of Medical Necessity determined by CMHA and no services requested or authorized beyond: *(Not applicable to inpatient)*				
D	Intake			X[1,3,4]
D	Previously authorized benefit			X[1,3,4]
KCMHP Determination that Services will be:				
E / F & I	Denied -- For Medicaid or First Priority Non-Medicaid clients includes failure to offer an intake or when a client meets medical necessity but no authorization requested--see P&P Attachment I	X[1,2]		X[1,3,4]
E / F	Reduced	X[2]		X[1,3,4]
E / F	Suspended	X[2]		X[1,3,4]
E / F	Terminated	X[2]		X[1,3,4]
E	Terminated due to loss of Medicaid	X[2]		

[1]Include right to a second opinion through the RSN and how to access the second opinion

[2]Include the right to a Grievance and an Administrative Fair Hearing

[3]Information on availability of other services under EPSDT

[4]If notice sent to client with "D" coupon, must also send copy to DSHS. The legal representative to receive notices on behalf of the client is the Children's Administration Regional office.

Failure to Offer Intake to a Medicaid or Apparently Eligible Non-Medicaid Client
or
Failure to Request Authorization When a Client Meets Medical Necessity Criteria

Client Name: _____

King County ID Number: _____

Agency Name or ID Number: _____

The above client is a (check one):

☐ Medicaid Enrollee

☐ Non-Medicaid client

The following event has occurred (check one):

☐ An intake was not offered subsequent to a request for services made on _____ (date).

☐ Following an intake on _____ (date) in which it was found that the client meets medical necessity criteria, this agency is not requesting an authorization.

Rationale for the above decision:

_____

_____

_____

Person completing this form: _____

Phone number for person completing this form: _____

Note: This form (or one containing the same information) must be **faxed** to KCMHP Clinical Team at 206-205-1634 within three working days of the date filled in above.

Office Use Only

This event was reviewed by _____ *on* _____ .

For the agency decision not to request an authorization, KCMHP:

☐ *Concurs*

☐ *Does not concur with the provider's decision. Action taken:*

_____

_____

The following form has been sent to the client:

☐ *Notice of Action for Medicaid client when no intake offered or no authorization request with KCMHP concurrence.*

☐ *Notice of Determination for Non-Medicaid client when no intake offered or no authorization request with KCMHP concurrence.*

IV. FINANCIAL MANAGEMENT

1.0 POLICY TITLE: FINANCIAL MANAGEMENT OF THE KING COUNTY MENTAL HEALTH PLAN (KCMHP)

1.1 Originally Implemented: April 1, 1995

Financial Management: April 1, 1995

1.2 Reviewed and revised: November 2014

1.3 Officially Adopted: January 2, 2015

1.4 Effective Date: February 2, 2015

1.5 Signed: _____
Jean Robertson, Assistant Division Director/RSN Administrator

2.0 PURPOSE: To describe the financial model for the fiscal management of the KCMHP and the policies governing provider billing and reimbursement.

3.0 POLICY/PROCEDURES/RESPONSIBILITIES:

3.1 Case Rate Model

3.1.1 Financial management of the KCMHP outpatient system is based on a case rate model that specifies the case rate based on the case rate criteria (see Section VI: Outpatient Services Level of Care, Attachment F).

A. There are different case rates for each of the two population groups to be served:

1. Children; and

2. Adults (including older adults).

B. The case rate payment is based on the individual's age at the beginning of the case rate authorization period.

C. If an 18- to 20-year-old is assessed as an adult, the adult case rate will be paid.

3.1.2 The hourly rate, which forms the basis of case rate payments, is established by the KCMHP.

3.1.3 The current case rates are included in this Section as Attachment A, Case Rates.

3.2 Benefit Package

3.2.1 An authorized benefit is an agreement between the provider and the KCMHP that, in return for a case rate payment, the provider shall assume the risk of providing all necessary outpatient treatment services for a client for the period of the benefit. The case rate the provider receives is based on case rate criteria.

3.2.2 An authorized benefit includes the following elements:

A. Case rate;

B. Duration; and

C. The range of available core services.

3.2.3 Any of the elements may change when a new benefit is authorized.

3.2.4 When changes are made to case rates, the authorized existing benefit shall continue and shall be paid under the new case rates.

3.3 Provider Case Rate Reimbursement

3.3.1 The approved case rate benefit shall start on the date of assessment except as follows:

A. For clients who need services to be continued beyond an existing benefit period a new authorized benefit begins no earlier than the day following the expiration of the previous authorized benefit; and

B. Waitlisted non-Medicaid clients begin on the day following their removal from the wait list.

3.3.2 The approved case rate benefit shall expire based on the authorized benefit expiration date unless it is terminated.

3.3.3 Payments shall be made for the duration of an authorized benefit, except when a Medicaid client loses Medicaid.

A. No Medicaid payment shall be made on behalf of a Medicaid client beyond the month in which Medicaid coverage expired.

B. If the expiration date has changed and a Medicaid payment has been made, an adjustment shall occur.

3.4 Cultural Differential and Language Differential

3.4.1 Cultural Differential

A. A case rate that includes additional payment for a cultural differential shall be paid for the care of any individual who receives a mental health specialist evaluation or consultation and:

1. Identifies as a member of an ethnic minority;
2. Identifies as a member of a sexual minority;
3. Is a person who is homebound due to medical problems and not living in a facility; or
4. Is a person who is deaf or hard of hearing.

B. Payment occurs when all of the following are submitted to KCMHP:

1. Either service code:
   a. T1023 for a face-to-face evaluation; or
   b. H0031 for a non-face-to-face consultation; and
2. Provider of the above service is a mental health specialist appropriate for the person's culture or disability; and
3. Additional information as follows:
   a. For ethnic minorities, either codes:
      i. 21 through 871 if ethnicity is non-Caucasian/white; or
      ii. 000 through 799 if Hispanic origin is identified; or
   b. For sexual minority, sexual minority status is code2 if "person states that he/she is a member of a sexual minority;" or
   c. For non-facility-based medically compromised homebound:
      i. Impairment kind is code is 43 "medically compromised;" and
      ii. In a qualifying residential arrangement code:
         a) 01 "Permanent housing unassisted;"
         b) 02 "Permanent housing assisted;"
         c) 03 "Temporary housing unassisted;"
         d) 04 "Temporary housing assisted;"
         e) 05 "Temporary housing dependent;"
         f) 06 "Transitional housing;"
         g) 22 "Adult Family Home;"
         h) 26 "Foster Care for children;" or

i) 82 “Homeless;” or

d. For deaf or hard-of-hearing persons, impairment kind is code:

i. 32 “deaf”; or

ii. 33 “hard of hearing.”

3.4.2 Language Differential

A. The language differential is an additional payment for individuals whose services are delivered in a language other than English.

B. This differential case rate exists to fund the specialized care needed to provide adequate services to members of these populations.

3.4.3 The cultural differential is separate from the language differential, so an individual may qualify for the both the cultural differential and the language differential.

3.4.4 No differential shall be paid for clients identified as requiring a cultural differential or language differential but for whom the data requirements as described in Section XII: Information Management, are incomplete.

3.4.5 If data that qualifies the client for a cultural differential or language differential is submitted within the first three calendar months, then the case rate is paid at the differential rate retroactive to the authorized benefit start date.

3.4.6 If data that qualifies the client is submitted after the first three calendar months, then the case rate shall be paid at the differential rate on the next monthly payment and going forward but not retroactively to the start date.

3.5 Recovery Incentives

3.5.1 The KCMHP may provide incentives for certain practices that promote recovery.

3.5.2 The incentives will be provided primarily as an enhancement to outpatient cases rates.

3.5.3 The KCMHP may also, at its discretion, provide certain incentives on a fee-for-service basis.

3.6 Case Rate Changes

3.6.1 Case Rate changes are allowed as specified in Section VI: Outpatient Services Level of Care.

3.6.2 For a case rate change that takes place within the initial time frames outlined in Section XII: Information Management, an adjustment to the payment is made, subsequent to the case rate change but retrospective to the assessment date, which shall take place in the next scheduled payment cycle. If a payment made to a provider is found to be incorrect, an adjustment to the payment amount shall be made according to adjustment procedures noted in this Section.

3.6.3 For any approved change that is initiated by KCMHP as part of concurrent or retrospective review, a new payment amount based on the new benefit shall be calculated in the next scheduled payment cycle.

3.6.4 For approved changes due to catastrophic and permanent change as outlined in Section VI: Outpatient Services Level of Care, a new full benefit shall be authorized on the date of the new assessment. The existing benefit shall expire one day prior to the new assessment date.

3.7 Provider Changes

3.7.1 Changes between providers for an authorized client during a benefit period shall start a new benefit period.

3.7.2 When a client changes providers mid-benefit, the existing benefit ends and a new authorized benefit is given. The receiving provider is required to submit a new authorization, flagged as a provider change as stated in Section XII: Information Management.

3.7.3 Payment to the new provider shall begin when all data required for a new benefit have been submitted as outlined in Section XII: Information Management. The first authorized benefit shall expire the day before the new date of assessment. Payments made to the first provider subsequent to the new assessment date shall be adjusted. Both fiscal actions shall occur in the next scheduled payment cycle.

3.8 Provider Reimbursement

3.8.1 Payments to providers for every authorized outpatient benefit or supportive housing benefit record in the system are based on case rate code, coverage, and the case rate table.

3.8.2 “Payment” is the monthly prospective and retrospective transfer of the case rate authorized to a provider according to their current case rate records.

A. Payment shall begin when an authorization has met the necessary data requirements as outlined in Section XII: Information Management.

B. Payment is prospective to the last day of the calendar month of payment or the expiration date of the benefit, whichever comes first.

C. Payment amount is based on the case rate code assigned to the authorization record at the time of the payment run, the client's coverage status in the payment month as known at the time of the payment run, and the dollar amount payable for that case rate code for the payment month described in the case rate table.

3.8.3 The payment process is set up on a monthly schedule based on the electronic information on record in the MHCADSD IS at the time the benefit authorization.

A. The payment shall be calculated using the daily case rate on the first working day of the month prospectively for a calendar month.

B. The payment shall be remitted to providers no later than the end of each calendar month.

3.8.4 Payment is due to the provider for each day in the calendar month during the benefit period that the provider-of-record was responsible for the client.

3.8.5 The start and expiration dates are counted as days for purposes of payment.

3.8.6 The provider shall maintain acceptable levels of all insurance required by contractor. Coverage shall be in effect for all days of the month in order for a prospective benefit payment or carve-out payment to be made for that month. Coverage information shall be received and approved by KCMHP before a payment shall be made.

3.8.7 If an authorization is not on record in the MHCADSD IS at the time that the prospective monthly payment is calculated, payment for that authorization shall begin as of the next payment cycle. A retrospective payment shall be made for benefit days provided prior to the calculation date.

A. Payment is retrospective where a payment was missed for an authorized benefit except for:

1. Any month where a suspended payment status is in effect for that month; and

2. Changes in coverage.

B. The time limit on retrospective payments is three years.

3.8.8 Payments for other residential services and all additional services are processed manually.

3.8.9 The payment audit process takes approximately 15 calendar days to complete. If KCMHP is not able to ensure payment to providers by the 15th of the month, providers shall be notified 10 days in advance of the 15th with a revised anticipated payment date.

3.8.10 The payment audit verification process is as follows:

A. A payment report for reimbursement is generated by the MHCADSD IS on the first working day of the month; and

B. KCMHP shall verify this report for compliance with policies.

3.8.11 KCMHP shall review and approve the total payment request.

3.8.12 Upon payment approval, KCMHP shall authorize providers to have online access to all payment information.

3.8.13 KCMHP payments and payment information shall be transferred to each provider. The fund transfer process between financial institutions shall occur within 48 hours.

3.9 Payment of Invoices

Providers shall submit invoices for additional services and residential services that are not paid through the case rate process.

3.9.1 Invoices shall be processed by KCMHP within 15 working days of receipt of invoice. If KCMHP is not able to process the invoice by the fifteenth working day, KCMHP shall notify providers no later than three days prior to the original deadline, with a revised anticipated approval date.

3.9.2 If the invoice requires communication with a provider to resolve discrepancies, KCMHP shall send a Provider Notice of Pended Invoice via email within three working days of the invoice being pended. KCMHP shall also initiate contact with the provider to begin resolution of the discrepancy.

3.9.3 KCMHP shall maintain a billing contact list for each provider that has at least two contacts identified for resolution of billing discrepancies.

3.10 Financial Adjustment

3.10.1 The KCMHP shall make adjustments to provider case rate payments when a case rate change is made in accordance with Section VI: Outpatient Services Level of Care or when data submission requirements for authorizations are not met in accordance with Section XII: Information Management.

A. There is no limit on the number of adjustments a benefit may have.

B. An adjustment may be a positive or negative dollar amount.

1. The amount of the adjustment for an interim benefit change is the difference between payments made under the previous case rate and the new case rate.

2. The amount of the adjustment for a canceled benefit is for every payment made from the start date of the authorized benefit.

3. The amount of the adjustment for a terminated benefit is for all payments made for the period after the termination date.

3.10.2 Cancellation

A. If the required case rate validation data is not received by the KCMHP by the end of the first calendar month following the month of assessment, all payments made to date shall be adjusted and the authorization canceled.

B. If the provider continues to require an authorization for this client, a new request shall be submitted and all data timelines/requirements shall begin again.

3.10.3 Suspension

A. If the required complete outcome data set is not received by the KCMHP by the end of the second month following the month of assessment, payment shall stop and the authorization shall be suspended.

1. When the outstanding data elements are received by the KCMHP, payment shall begin to calculate on the next scheduled payment cycle.

2. Retrospective partial months shall not be paid.

B. When a Medicaid client loses their Medicaid coverage (payment suspended upon loss of coverage).

3.10.4 Termination

A. Adjustments shall be made and payments terminated when the circumstances described below occur, or in accordance with the criteria outlined in Section VI: Outpatient Services Level of Care; the benefit shall end as of the date of termination.

B. Payments made subsequent to the termination date shall be adjusted in the next scheduled payment cycle.

C. Death of Client

When a client dies during an authorized benefit period, the authorized benefit shall end on the date of death.

D. Long-Term Rehabilitative (LTR) Placement

When a client is authorized for LTR placement, payment for any open benefit shall cease on the day before LTR residency begins.

E. Client Moves Out of King County

The authorized benefit shall end on the date the client moves out of King County.

F. Client Gains Resources

When an authorized client gains enough resources during his or her benefit period to be treated as a private-pay client by the provider.

G. Co-Occurring Disorder (COD) Placement

1. When a client is authorized for COD placement, payment for any open benefit shall cease on the day before the COD benefit begins.

2. The provider initiating the COD benefit shall contact KCMHP Clinical Services to coordinate the termination of the previous benefit.

H. If a provider requests and is approved for an optional termination of an authorized benefit, the payment shall cease on the date of termination.

3.10.5 If the KCMHP determines that payments have been made for one client with two simultaneous authorizations, all providers involved shall be contacted. KCMHP shall review the circumstances of the simultaneous authorizations and the clinical appropriateness of the benefits. A financial adjustment shall occur so that only one case rate at most is paid for a client.

3.10.6 A fiscal adjustment is made to a benefit payment when a change in the authorization results in the need to adjust the amount paid to the provider.

3.10.7 Providers shall receive an adjustment file each month listing all adjustments.

3.10.8 The adjustment verification process is as follows:

A. An adjustment report is generated by the MHCADSD IS on the first working day of the month;

B. KCMHP shall verify this report for compliance with policies;

C. KCMHP shall include the adjustment amount with the total KCMHP payment amount;

D. KCMHP shall coordinate adjustments to be deducted or added to payment amounts prior to funds being transferred; and

E. KCMHP shall send payment notification to each provider. This notification shall include amount of payment, amount of adjustment, and expected date of transfer.

3.11 Financial Exception to Policy

3.11.1 Providers may apply for an exception to policy for reimbursement. The KCMHP shall consider requests:

A. When events have occurred beyond the control of the KCMHP and its providers; or

B. Where KCMHP actions have prevented a provider from complying with standard policy and the provider has made efforts to mitigate the impact of the action where possible.

3.11.2 Prior to the review of any exceptions, providers must designate those employees who are authorized to request an exception to policy. Thereafter, exceptions shall only be considered when submitted by those identified staff. All other requests shall be returned without review.

3.11.3 All requests for an exception to policy must be submitted in writing to KCMHP. The request shall include:

A. Name, title, and phone number of provider staff requesting the exception;

B. King County ID (as identified in the MHCADSD IS) and provider ID;

C. Authorization number of the benefit involved;

D. Name of KCMHP staff involved in authorization;

E. Date of requested exception to policy (e.g., assessment/transfer date);

F. Type of exception being requested in detail; and

G. The reason for the request, the actions taken by the provider to resolve the particular issue and a statement on measures the provider is taking to ensure the problem is addressed in the future.

3.11.4 KCMHP shall review all exception to policy requests. Various KCMHP staff may be asked to comment if the situation requires additional feedback.

A. A request for an exception does not guarantee that an exception shall be approved. Approval for an exception to policy is solely a KCMHP decision.

B. Providers shall be notified in writing by KCMHP of a denial to an exception request within 10 calendar days of receiving the complete request. Providers shall be notified of all approvals through existing standard error reports and authorization response tables.

C. KCMHP shall maintain a log of exception to policy requests.

D. Exception to policy requests received after the 25th day of any given month shall not be processed until the following month.

E. When an exception to policy is approved, any payment and/or adjustment needed shall take place in the next scheduled payment cycle.

F. Exception to policy payments and/or adjustments shall be identified as such in the MHCADSD IS.

3.12 Non-Medicaid Resources

3.12.1 The amount of system-wide resources for non-Medicaid clients shall be determined on a periodic basis, based on the financial model forecast. The Mental Illness and Drug Dependency (MIDD) sales tax greatly expanded non-Medicaid funding beginning in late October of 2008 (see Attachment B, Scenarios for MIDD Authorizations).

3.12.2 KCMHP shall determine the system-wide dollar amount that is available for non-Medicaid outpatient benefits in each calendar year.

3.12.3 KCMHP shall make an estimate of the amount of this resource that is encumbered by benefits authorized in the previous calendar year that shall continue to require reimbursement in the current calendar year.

3.12.4 Based on that estimate, KCMHP shall determine the dollar amount that is available for new non-Medicaid benefit authorizations each quarter.

3.12.5 The dollar amount shall be updated as non-Medicaid expenditures are authorized for regular benefits and benefits authorized through the exception policy (see Section VI: Outpatient Services Level of Care).

3.12.6 KCMHP may change the amount of total dollars available for non-Medicaid benefits at any time during the calendar year.

3.12.7 Providers shall convert all non-Medicaid clients who are eligible for Medicaid before the beginning of the client's next benefit. Providers shall document activities undertaken to evaluate eligibility and efforts made to effect conversion.

3.12.8 In order to maximize the appropriate utilization of the limited non-Medicaid resource, providers shall update the client funding source upon change, as specified in Section XII: Information Management.

3.13 Coordination of Other Resources

3.13.1 Third-Party Benefits

A. Providers shall retain any third-party (Medicare and private insurance) reimbursement they collect on authorized clients. For that reason, the case rate includes a coordination of benefits discount.

B. Providers shall develop policies and procedures to aggressively pursue collection and documentation of all third-party benefits. Providers shall utilize separate coding in their accounting system to clearly segregate third-party payments from other payments.

3.13.2 First-Party (Private Pay) Payments by Non-Medicaid Clients

A. Providers shall implement a sliding fee scale according to Revised Code of Washington (RCW) 71.24.215.

B. Funds collected from a client without Medicaid must be refunded if the client subsequently receives retrospective Medicaid coverage.

C. Services funded by KCMHP may not be withheld by a provider due to the failure of a client without Medicaid to make a first party payment.

3.13.3 First-Party Payments by Medicaid Clients

A. Providers (and subcontractors) shall not collect first-party payments from Medicaid clients for any Medicaid covered services, even if KCMHP fails to provide payment. A Medicaid client cannot be held liable for any Medicaid-covered service in the event of:

1. The KCMHP's insolvency;

2. The State's failure to pay the KCMHP;

3. KCMHP's failure to pay a provider;

4. A provider's failure to pay a subcontractor;

5. The cost of a service provided on referral by KCMHP to an out-of-network provider exceeds what KCMHP would cover if provided within the KCMHP provider network; or

6. A community psychiatric hospital's insolvency.

B. Upon approval by KCMHP, providers may collect first-party payment from a Medicaid client:

1. For covered services if services are provided pending a client-initiated appeal of an adverse authorization decision and the client loses the appeal; and

2. For non-covered services if the requirements of Washington Administrative Code (WAC) 388-502-0160 or its successor are met and, prior to the provision of services, KCMHP has made a written determination that KCMHP does not cover these services. Inquiries should be directed to the KCMHP Fraud, Waste, and Abuse Compliance Officer.

C. Providers are required, per Medicaid rules, to refund to Medicaid-enrolled clients any first-party payments made by the client to the provider during any period the client had a KCMHP benefit.

D. Under no circumstances may a publicly funded client be billed for a failure to keep a scheduled appointment.

3.14 Spenddown

3.14.1 Spenddown Definition

Spenddown refers to the amount of medical expense for which the client is responsible. Spenddown occurs when the client's income and resources are above the limits set by the state for receiving Medicaid coverage.

3.14.2 Provider Responsibility regarding spenddown and Medicaid Coverage

Providers are expected to actively work with clients on spenddown so that the clients may regain their Medicaid coverage as soon as possible.

3.14.3 Use of Outpatient Benefit payments toward spenddown

Providers may apply the monthly amount of a client's non-Medicaid outpatient benefit payment to the client's spenddown requirement after that month's payment has been made to the provider by KCMHP, usually by the middle of the month.

3.15 Client Participation Payments

3.15.1 Clients shall pay a portion of their costs for food, lodging, and care when they are authorized to KCMHP residential facilities.

3.15.2 The provider shall be responsible for ensuring an accurate calculation of client participation to ensure that clients contribute an appropriate amount towards the cost of residential care.

3.16 Extraordinary Treatment Plan Payments

3.16.1 Extraordinary Treatment Plan (ETP) requests shall be approved by KCMHP as outlined in Section VI: Outpatient Services Level of Care.

3.16.2 Payments for actual costs as approved in the ETP request authorization notice shall be disbursed monthly upon receipt and approval of invoice for actual costs.

3.17 Homeless Outreach Stabilization and Treatment (HOST) Clients

Clients who are part of the HOST program shall not be authorized to an outpatient level of care and paid a case rate except as described in Section IX: Additional Services.

3.18 Medicaid Personal Care

3.18.1 Release of funds shall be made when actual expenditures have been incurred and invoiced to the KCMHP, and validated.

3.18.2 KCMHP will make payment to the state for these services.

3.19 Claims for Out-of-Area Emergency Services and Out-of-Network Services

3.19.1 Claims shall be submitted to KCMHP for payment consideration for:

A. Emergency services provided to KCMHP Medicaid clients when out of the KCMHP service area (see Chapter 388-865 WAC or its successor).

B. KCMHP pre-approved services provided outside the provider network when the network does not have capacity and/or specialty services available.

3.19.2 If deemed valid, the client shall be reimbursed on a fee-for-service basis as determined by the KCMHP on a case-by-case basis.

3.20 Uniform Cost Reporting

3.20.1 Providers shall report expenditures and revenues associated with mental health services for KCMHP clients using the Revenue and Expenditure (R&E) report form. The intent of the report is to measure expenditures associated with the provision of mental health services, which may include direct or indirect costs as described in federal guidelines including Office of Management and Budget (OMB) circulars and the current Budgetary Accounting and Reporting System (BARS) Supplementary Instructions for Mental Health Programs.

3.20.2 R&E reports shall be completed in accordance with uniform cost reporting standards using the format provided.

A. Providers are responsible for ensuring that the reports they submit are prepared in accordance with the version of BARS in effect for the time period covered.

B. Revenue categories associated with mental health services for KCMHP clients are defined by the BARS Supplementary Instructions for Mental Health Programs that are in effect at the time the R&E Report is prepared.

C. The Department of Social and Health Services (DSHS) Division of Behavioral Health and Recovery develops the format of the report.

3.20.3 Providers are responsible for completing a report that shows their expenditures in the BARS reporting format.

A. Expenditures associated with mental health services for KCMHP clients shall be reported by cost centers.

B. A cost center may include direct or indirect costs as defined by OMB Circular A87 and its successors.

C. A cost center shall be used to track costs that are specifically identified with a particular area, whether administrative, direct service support, or direct service.

1. Such cost centers shall be used to charge, assign, or allocate according to generally accepted accounting practices, Federal OMB circulars, the BARS Supplementary Instructions for Mental Health Programs, and other financial regulations determined applicable by the Washington State Auditor's Office, and their successors.

2. A cost center is a program named after the primary service it offers.

3. Other services, in addition to the primary service, may be offered within the cost center.

3.20.4 The agency shall complete the R&E report form by stating revenues and expenditures within categories defined for the current reporting period.

3.20.5 The R&E report shall be prepared for each quarter of the calendar fiscal year:

A. January through March;

B. April through June;

C. July through September; and

D. October through December; or

E. With greater or lesser frequency as communicated by KCMHP.

3.20.6 KCMHP requires providers to submit R&E reports within 30 days after the end of the quarter.

3.21 Audited Annual Financial Statements

Providers must send a copy of their audited annual financial statements to the County within a month of receiving them from their auditor or six months after the end of their fiscal year, whichever is sooner.

3.22 Medicaid Fraud, Medicaid Waste, and Medicaid Abuse

The KCMHP, its providers, and their subcontractors:

3.22.1 Are required to guard against Medicaid fraud, Medicaid waste, and Medicaid abuse through prudent fiscal and record keeping policies, procedures, and/or practices;

3.22.2 Shall comply with all reporting and other anti-fraud, anti-waste, and anti-abuse requirements, including the KCMHP Fraud, Waste, and Abuse Plan (see Section XIV and related Attachments); and

3.22.3 Shall cooperate with the KCMHP and the Washington State Attorney General's Medicaid Fraud Control Unit relevant to any investigation of alleged fraud, waste, or abuse.

3.23 Administrative Services

3.23.1 The KCMHP shall ensure that the majority of its funds are used for direct services and related activities provided to or for clients' mental health or psychiatric needs.

3.23.2 A minimum of 80 percent of the available funds in the system shall go to mental health direct services. A maximum of 10 percent may be used for the County's administrative costs.

3.23.3 If a provider receives an increase in revenue over the revenues received in the previous half year, the provider shall ensure that direct service expenditures increase in proportion to the increase in revenues received.

3.23.4 The KCMHP may set a different ratio of direct mental health services funds for each provider as long as the system-wide ratio as stated above is maintained.

3.24 KCMHP Reserve Accounts

3.24.1 The KCMHP shall maintain reserve accounts beyond those required by the County that shall be spent as necessary on the following:

A. Close-out expenditures should the County terminate KCMHP operations; and

B. When system expenditures exceed the available revenue and undesignated fund balance and the imbalance of revenue and expenditure has not been reversed by the end of the calendar year.

3.24.2 The KCMHP shall maintain reserves as required by contract and per King County policy. If expenditures are made from the reserves during a calendar year and the KCMHP is not terminating operations in that calendar year, the reserve levels shall be built back to the required levels in the subsequent calendar year.

4.0 LIST OF ATTACHMENTS:

4.1 Attachment A: Case Rates

4.2 Attachment B: Scenarios for MIDD Authorizations

5.0 REFERENCES:

FINANCIAL MANAGEMENT

Washington State Law, Regulations, and Policy including any successor, amended, or replacement laws, regulations, or policies

- Chapters 388-865, 388-877, and 388-877A WAC – Department of Social and Health Services – Mental Health – Community Mental Health and Involuntary Treatment Programs
- RCW 71.24.215 – Mental Illness – Community Mental Health Services Act – Clients to be Charged for Services

Other

- The current DSHS State Mental Health Contract and any subsequent amendments.
- The current DSHS PIHP Contract and any subsequent amendments.

SPENDDOWN

Washington State Law, Regulations, and Policy including any successor, amended, or replacement laws, regulations, or policies

- Department of Social and Health Services
  - Eligibility A-Z Manual, Medical Assistance – Spenddown (http://www.dshs.wa.gov/manuals/eaz/sections/MedicalAssistance/Spenddown.shtml, as revised February 2, 2010).
  - Automated Client Eligibility System (ACES) User Manual, Spenddown (http://www.dshs.wa.gov/manuals/aces/index.shtml, as revised June 9, 2010).
- WAC 388-416-0020 – Certification Periods for the Non-Institutional Medically Needy Program.
- WAC 388-519-0100 and 0110 – Spenddown.

2015 Medicaid CASE RATES

2015 increase 7.5% 365 days

UNIFORM BENEFIT		Adult Total Case Rate	Adult Daily Rate	Child Total Case Rate	Child Daily Rate
2	Maintenance	1,981.49	5.43	2,381.72	6.53
3a	Rehabilitation	2,886.69	7.91	3,056.60	8.37
3b	Exceptional Care	8,475.02	23.22	11,716.32	32.10

UNIFORM BENEFIT WITH LANGUAGE DIFFERENTIAL		Adult Total Case Rate	Adult Daily Rate	Child Total Case Rate	Child Daily Rate
2	Maintenance	2,079.59	5.70	2,503.35	6.86
3a	Rehabilitation	3,025.21	8.29	3,205.70	8.78
3b	Exceptional Care	8,902.99	24.39	12,304.88	33.71

UNIFORM BENEFIT WITH CULTURAL DIFFERENTIAL		Adult Total Case Rate	Adult Daily Rate	Child Total Case Rate	Child Daily Rate
2	Maintenance	2,267.93	6.21	2,703.46	7.41
3a	Rehabilitation	3,170.42	8.69	3,378.35	9.26
3b	Exceptional Care	8,775.20	24.04	12,034.14	32.97

UNIFORM BENEFIT WITH CULTURAL & LANGUAGE DIFFERENTIAL		Adult Total Case Rate	Adult Daily Rate	Child Total Case Rate	Child Daily Rate
2	Maintenance	2,385.64	6.54	2,836.87	7.77
3a	Rehabilitation	3,335.19	9.14	3,547.07	9.72
3b	Exceptional Care	9,216.89	25.25	12,642.32	34.64

HOLD HARMLESS		Adult Total Case Rate	Adult Daily Rate	Child Total Case Rate	Child Daily Rate
2	Maintenance	2,201.22	6.03	2,417.03	6.62
3a	Rehabilitation	3,197.86	8.76	3,099.76	8.49
3b	Exceptional Care	9,424.85	25.82	11,892.89	32.58

HOLD HARMLESS WITH LANGUAGE DIFFERENTIAL		Adult Total Case Rate	Adult Daily Rate	Child Total Case Rate	Child Daily Rate
2	Maintenance	2,303.24	6.31	2,542.59	6.97
3a	Rehabilitation	3,362.65	9.21	3,252.79	8.91
3b	Exceptional Care	9,891.77	27.10	12,489.30	34.22

HOLD HARMLESS WITH CULTURAL DIFFERENTIAL		Adult Total Case Rate	Adult Daily Rate	Child Total Case Rate	Child Daily Rate
2	Maintenance	2,530.82	6.93	2,742.70	7.51
3a	Rehabilitation	3,527.45	9.66	3,429.36	9.40
3b	Exceptional Care	9,750.52	26.71	12,222.48	33.49

HOLD HARMLESS WITH CULTURAL & LANGUAGE DIFFERENTIAL		Adult Total Case Rate	Adult Daily Rate	Child Total Case Rate	Child Daily Rate
2	Maintenance	2,648.53	7.26	2,887.88	7.91
3a	Rehabilitation	3,700.10	10.14	3,598.08	9.86
3b	Exceptional Care	10,233.14	28.04	12,830.66	35.15

King County RSN
Scenarios for MIDD Authorizations
Updated: June 10, 2009

Basic Premise(s):

Access for First Priority non-Medicaid clients will be ensured

Reporting Elements	Scenario 1	Scenario 2	Scenario 3	Scenario 4	Scenario 5
	Lost Medicaid (MC), request for MIDD funding w/in 12 months of MC authorization	Lost Medicaid with a gap in services of >90 days, request for MIDD funding >12 months after prior authorization	Started w/ MIDD funding, then became Medicaid eligible w/in 12 months	Served with no prior Medicaid or State Only funding, no authorization w/in 12 months, request for MIDD funding	Started with MIDD or State Only funding, became Medicaid eligible w/in 12 months, and then lost Medicaid
Request for Service	Use initial request date	Submit request date	Use initial request date (data anomaly for MHD monitoring[3])	Submit request date	Use initial request date (data anomaly for MHD monitoring[3])
Intake by MHP within 10 working days	Use initial MHP intake	New MHP intake	Use initial MHP intake	Use initial MHP intake if done w/in prior 12 months, otherwise new MHP intake	Use initial MHP intake
Auth Request within 9 days	Submit request when aware of loss of MC, Must meet non-MC criteria	Yes	Automatically converted to MC by King County, no authorization request needed (data anomaly for MHD monitoring[3])	Yes	Automatically converted to original MIDD or State Only funding by King County, no authorization request needed (data anomaly for MHD monitoring[3])
Authorization within 5 days	Yes	Yes	N/A, same authorization, only change in fund source	Yes	N/A, same authorization, only change in fund source
Services Start within 28 days of Request for Service	N/A, assumes no break in services	Yes	Yes, assumes no break in services (data anomaly for MHD monitoring[3])	Yes	Yes, assumes no break in services (data anomaly for MHD monitoring[3])
Benefit Period	New start and end dates	New start and end dates	Use original start and end dates	New start and end dates	Use original start and end dates
Continued Services	May request additional 12-month benefit	May request additional 12-month benefit	May request additional 12-month benefit	May request additional 12-month benefit	May request additional 12-month benefit
Termination of Services	Submit exit reason "07" client lost MC and eligible for non-MC (MIDD) funding[1]	If services terminated prior to end of MIDD benefit, use appropriate exit code	If services terminated prior to end of MC benefit, use appropriate exit code	If services terminated prior to end of MIDD benefit, use appropriate exit code	If services terminated prior to end of benefit, use appropriate exit code
Notice to Client	NOD-C[2] with new authorization time frames	NOD-C with new authorization time frames	N/A, same authorization, only change in fund source	NOD-C with new authorization time frames	N/A, same authorization, only change in fund source

[1]If a person loses MC and will be terminated because he/she doesn't meet First or Second Priority non-Medicaid criteria, submit exit reason "06"

[2]NOD-C refers to the P&Ps, Section III, Attachment C; this letter informs clients they have been authorized for services and the start and end dates

[3]MHD performance measure -- request for service to first routine service does not exceed 28 days for clients authorized for services

V. CRISIS SERVICES LEVEL OF CARE

1.0 POLICY TITLE: MENTAL HEALTH CRISIS SERVICES

1.1 Originally Implemented: April 1, 1995

1.2 Reviewed and revised: November 2014

1.3 Officially Adopted: January 2, 2015

1.4 Effective Date: February 2, 2015

1.5 Signed: _____
Jean Robertson, Assistant Division Director/RSN Administrator

2.0 PURPOSE: To describe the crisis mental health services available to all persons not currently receiving services in the outpatient level of care.

2.1 The intent of crisis services is to respond to urgent and emergent mental health needs of persons in the community.

2.2 The goal of crisis services is to stabilize the individual and family in the least restrictive setting appropriate to their needs, considering consumer strengths, resources, and choice. Interventions shall be age and developmentally appropriate and shall contribute to and support the individual's innate resiliency. For persons with a previously identified mental illness, crisis services will be delivered in a manner that supports the individual's recovery.

3.0 ELIGIBILITY:

3.1 Eligibility for Crisis Services

3.1.1 Crisis services shall be available to any person at no cost, regardless of income, age, or residency, who is experiencing a crisis in King County. Eligibility for the full range of services is limited by the following:

A. Persons who are enrolled in the outpatient level of care receive crisis services from their outpatient provider, except for:

1. Crisis diversion services (Crisis Diversion Facility, Crisis Diversion Interim Services, and Mobile Crisis Team);

2. Inpatient diversion beds; and

3. Crisis and Commitment Services (CCS) involuntary detention services.

B. Persons who are residents of King County but not enrolled in the outpatient level of care may receive:

1. 24-hour phone line (Crisis Clinic);

2. Telephone screening services;

3. Next-day appointment (NDA) services for adults and older adults;

4. Children's Crisis Outreach Response Services (CCORS);

5. Crisis diversion services (Crisis Diversion Facility, Crisis Diversion Interim Services, and Mobile Crisis Team);

6. Inpatient diversion beds; and/or

7. CCS outreach and involuntary detention services.

C. Persons who are not residents of King County may receive:

1. 24-hour phone line (Crisis Clinic);

2. Telephone screening services;

3. CCS outreach and involuntary detention services;

4. CCORS; and/or

5. Crisis diversion services (Crisis Diversion Facility, Crisis Diversion Interim Services, and Mobile Crisis Team).

3.2 Medical necessity criteria

Crisis services shall be available for any person for whom a mental illness or emotional disturbance may be present.

3.3 Authorization

Authorization cannot be required for this level of care.

3.4 Continuing Stay Criteria

3.4.1 Crisis services are continued until the person no longer meets the eligibility and/or medical necessity criteria or until the person is transitioned to another source and/or level of care.

3.4.2 Referrals

A. Adult Crisis Services, CCORS, or the Designated Mental Health Professionals (DMHPs) may refer to a provider for outpatient level of care if the person referred meets both medical necessity criteria and financial eligibility criteria as stated in this Section.

B. The Crisis Clinic, CCORS, or DMHPs shall make referrals for NDAs and non-emergency outreaches (NEOs) and for outpatient level of care authorizations based on the person's area of residence, individual or family preference, and cultural appropriateness. NDAs and NEOs will be scheduled through the Crisis Clinic and shall include access to a face-to-face appointment with a psychiatrist or Advanced Registered Nurse Practitioner (ARNP) based on clinical need.

3.5 Termination and discharge criteria

The client is discharged from crisis services when he/she no longer meets the eligibility and/or medical necessity criteria and/or has been transitioned to another source and/or level of care.

3.6 Notices

There are no Notice of Action or Notice of Determination requirements for the Crisis Services Level of Care.

3.7 Provider appeals

There is no appeal process for the Crisis Service Level of Care.

4.0 POLICY/PROCEDURES/RESPONSIBILITIES:

4.1 For crisis mental health services available for persons authorized to an outpatient benefit, see Section VI: Outpatient Services Level of Care.

4.2 Statutory requirements amended into Chapter 71.24 Revised Code of Washington (RCW) in 2007 and Chapter 388-877A-0240 Washington Administrative Code (WAC) concerning safety of crisis workers, are reflected in outpatient contract exhibits and in CCS policies and procedures.

4.3 Information must be provided to persons who are in crisis in a manner that they can understand in accordance with the requirements in Section III: Client Rights.

4.4 Description of services offered in King County for persons who are not enrolled in an outpatient benefit.

4.4.1 Crisis services for all ages

A. 24-hour phone line providing crisis intervention, referral information about available services, linkage to treatment resources including NDAs and/or NEOs, and other information as necessary.

B. Crisis and Commitment Services (CCS)

1. DMHPs are available for initial crisis outreach only for persons age 13 or older. The need for initial crisis outreach is determined by following the procedures outlined in the Standardized Initial Crisis Screening Protocol (SICSP) minimum requirements (Attachment A).

2. DMHPs also provide evaluations for involuntary detentions of persons age 13 or older.

4.4.2 Crisis services for adults only

A. NDAs for referrals made in accordance with the King County Crisis Response System Next-day Appointment Minimum Requirements (Attachment B);

B. Crisis stabilization services;

C. Crisis diversion services (Crisis Diversion Facility, Crisis Diversion Interim Services, and Mobile Crisis Team); and

D. Inpatient diversion beds:

1. These are available to all adults who are King County residents, who can be appropriately diverted from an inpatient psychiatric hospital admission if given this service.

2. Referrals to these beds are made by DMHPs or by Crisis Clinic staff.

3. An initial referral is for five working days. Stays beyond this time frame can be approved in extraordinary circumstances by a King County Mental Health Plan (KCMHP) care manager.

4.4.3 Crisis services for children

A. CCORS providers will provide the following services for children and youth, ages 3 through 17 years old. These services will be provided through outreach and crisis stabilization, depending on the needs of the person being served.

1. Crisis outreach services accessible 24 hours a day, 7 days a week to occur at the location of the crisis.

2. Crisis stabilization placements that provide short-term, immediate out-of-home placements for families that lack resources or natural supports to safely rely upon.

3. Crisis stabilization services that includes referral, advocacy, and support to families and youth through connection to community and natural supports, as well as linkages to appropriate services.

4. NEOs for referrals made in accordance with the King County Crisis Response System Next-day Appointment Minimum Requirements (Attachment B).

5. For children at risk of placement disruption, Intensive Stabilization Services (ISS): an intensive service delivery lasting up to 90 days providing families and youth with immediate crisis stabilization to prevent disruption of the current living situation (see Attachment C: Intensive Stabilization Services Referral Form).

B. Inpatient Diversion Beds are available to children and youth who are authorized for outpatient level of care and who can be appropriately diverted from an inpatient psychiatric hospital admission if given this service.

1. Referral to these beds are made by outpatient services provider crisis staff or mental health care provider by calling the CCORS program directly.

2. An initial referral is for 72 hours. Stays beyond this time frame must be approved by CCORS staff and/or KCMHP clinical staff.

4.5 Time frames

4.5.1 Client need shall always determine response time.

4.5.2 Emergent care are those services that, if not provided, would likely result in the need for crisis intervention or hospitalization due to imminent concerns about potential danger to self, others, or grave disability. Emergency crisis services must be initiated within two hours of the initial request from any source. Examples include phone crisis services, CCS services, CCORS services, inpatient diversion beds, and crisis stabilization services.

4.5.3 Urgent care are those services that, if not provided, would result in decompensating to the point that emergency care is necessary. Urgent crisis services must be initiated within 24 hours of the initial request from any source. Examples include CCS services, CCORS services, inpatient diversion beds, and crisis stabilization services.

4.6 Documentation requirements

4.6.1 All crisis services provided by the agency shall be documented in the client's clinical record in accordance with WAC 388-877A, or its successor.

A. Each printed page of the record must contain the individual's name and agency record number.

B. Documentation must include the date and time each request for crisis response was received, the date and time each response was provided, and an indication whether the response was face-to-face.

C. Documentation must demonstrate that emergent crisis services are provided within two hours of the request for service.

D. Documentation must demonstrate that urgent crisis services are provided within 24 hours of the request for such services or provide a clinical justification if they were not.

E. The narrative description of the service must provide sufficient information that can be translated to a service description title or crisis service code.

4.7 CCS and providers shall follow the integrated co-occurring disorder screening and assessment process required by the Department of Social and Health Services (DSHS) (see Section VI: Outpatient Services Level of Care). Staff using the DSHS tool for this process shall attend trainings on the use and implementation of the tool.

4.8 KCMHP and providers shall participate in all disaster preparedness activities and respond to emergency/disaster events (e.g., natural disasters, acts of terrorism) when requested by DSHS.

5.0 INFORMATION SYSTEMS BUSINESS RULES:

5.1 Providers shall ensure that all data stored on the MHCADSD IS describing the client and any services received in the Crisis Services Level of Care are complete and accurate.

5.2 Reporting requirements are articulated in crisis services contracts.

6.0 FINANCIAL BUSINESS RULES:

Payment for providing the Crisis Services Level of Care is described in individual provider contract exhibits.

7.0 LIST OF ATTACHMENTS:

7.1 Attachment A: Standardized Initial Crisis Screening Protocol (SICSP)

7.2 Attachment B: Next-day Appointments and Non-emergent Outreach Minimum Requirements for Crisis Response System

7.3 Attachment C: Intensive Stabilization Services Referral Form

8.0 REFERENCES:

Washington State Law, Regulations, and Policy including any successor, amended, or replacement laws**,** regulations**,** or policies

- Chapter 71.05 RCW – Mental Illness – Mental Illness
- Chapter 71.24 RCW – Mental Illness – Community Mental Health Services Act
- Chapter 71.34 RCW – Mental Illness – Mental Health Services for Minors

- Chapters 388-865, 388-877, and 388-877A Washington Administrative Code – Department of Social and Health Services – Mental Health – Community Mental Health and Involuntary Treatment Programs

Other

- Federal 1915(b) Waiver Renewal
- The current Department of Social and Health Services (DSHS) State Mental Health Contract and any subsequent amendments
- The current Department of Social and Health Services (DSHS) PIHP Contract and any subsequent amendments

Minimum Requirements for Standardized Initial Crisis Screening Protocol (SICSP)

Purpose:

To define the minimum requirements and procedures for screening and referral of individuals in crisis.

Eligibility Criteria:

Persons eligible for crisis services must meet the following criteria:

1. Be authorized for an outpatient level of care; **or**

2. A mental disorder or serious emotional disturbance (for children under age 21 only) cannot be ruled out **and** at least one of the following applies:

    a. The person demonstrates or reports a marked deterioration in her/his usual level of functioning; **or**

    b. The usual family supports are not available or are exhausted and/or community supports are not available. "Community support not available" does not include persons whose tier benefit is terminated as a result of changes in the non-Medicaid criteria or in the medical necessity criteria.

Services Covered By This Protocol:

1. Initial crisis outreach services provided by a County-Designated Mental Health Professional (DMHP).

2. Walk-in services provided by all providers.

3. Telephone crisis response provided by any provider including the Crisis Clinic and the DMHPs.

4. Outreach and assessment services provided by the Children's Crisis Outreach Response System (CCORS) and the Geriatric Regional Assessment Team (GRAT).

5. Referrals between and among all providers, the Crisis Clinic, and the DMHPs.

Protocol:

This protocol shall be used when a telephone call from a person requesting crisis services is received by or transferred between any provider including the Crisis Clinic and the DMHPs, or when a person in crisis who is not authorized for outpatient level of care services walks in to any provider. Staff at the agency that initially receives the crisis contact shall carry out the service requirements specified in this protocol.

Professional staff authorized by the KCRSN shall use the Client Look-up System (CLS) to determine if the individual is authorized for an outpatient level of care and/or the Regional Support Network (RSN) Demographic Search, Washington State's computer system client database, to determine authorization status.

Uniform Screening Information:

During initial screening of calls, crisis telephone staff shall cover the following areas:

1. Ensurance of safety – the imminence of danger and the presenting problems;
2. Enrollment status and current service providers including both mental health and other social and health service providers;
3. Demographics – name, date of birth/age, telephone number, address, current location, ethnicity, language, hearing impairment;
4. Violence – current threats or acts of violence, history of violence, presence of weapons including what weapons are accessible;
5. Referral source – agency/person's name and telephone number;
6. Substance use, including tobacco use – history, current;
7. Medical status – history, current, medications, health care provider;
8. Physical status, mobility;
9. Psychiatric history – outpatient, inpatient, suicidal ideation/attempts;
10. Legal status;
11. Time and date of referral;
12. Willingness to accept intervention; and
13. Services needed – outreach, in-facility, other.

Screening Steps:

Crisis staff shall follow these steps to assess the situation and serve the caller:

1. **Ensure safety of the caller or individual referred.** In all cases where an individual is involved in an immediate life-threatening emergency that requires the intervention of police or emergency medical personnel, staff shall take all measures possible to ensure the individual's safety.
2. **Determine if the caller is a police officer.** If so, staff will find out: 1) name of the person the officer is calling about; 2) location of that person; 3) name of the officer; and 4) phone number where the officer can be reached.
    a. If the individual is authorized to an outpatient level of care, staff will call the client’s case management team and request that they call the officer back.

b. If the individual is not authorized to an outpatient level of care, staff in consultation with the police officer will determine the need for an immediate outreach assessment. If an immediate outreach is needed, staff will call the CCORS (children ages 3 through 18) or the DMHPs (age 13 and older, only if youth not willing to accept voluntary service) and ask them to call the officer back.

c. If the individual is not authorized to an outpatient level of care and not in need of an immediate outreach, staff will determine whether or not the individual is currently being seen for any services in the King County Mental Health Plan (KCMHP). If the individual is currently being seen, staff will inform the provider of the telephone contact as soon as possible but no later than close of business of the current day or, if the telephone contact occurs outside of usual business hours, at the start of business of the next working day. If the person is not currently being seen, staff will call the CCORS, GRAT, or the DMHPs.

3. For non-police referrals, **determine whether the caller or individual referred is authorized**. If so, staff will call the provider case management team and request services on the client's behalf.

4. **Determine if the individual is experiencing a mental illness or emotional crisis**.

   a. If the caller or person referred is **not** experiencing a mental illness or emotional crisis, the professional staff will attempt to address the concerns and resolve the situation or refer the caller to an appropriate service provider.

   b. Callers who are experiencing a mental illness or emotional crisis or who are referring someone who is experiencing a mental illness or emotional crisis will be further evaluated by the crisis staff.

5. **Determine if the individual is in treatment in the private sector.**

   a. If the caller or person referred is experiencing a mental illness or emotional crisis and staff have determined that the caller is receiving treatment in the private sector, staff will contact the private provider and ask if he/she will agree to try to resolve the crisis.

   b. If the private provider agrees to intervene, staff will provide information on the current problem and negotiate an acceptable disposition.

   c. If unable to reach the private provider while the caller is still on the line **or** if the private provider does not agree to try to resolve the crisis **or** if the staff member and the private provider cannot agree on a course of action, crisis staff will proceed with the call.

6. **Determine if the person is in need of an immediate outreach.** Having already determined that 9-1-1 intervention is not necessary (step one), staff will determine if there are other immediate threats to the safety or well being of the caller, individual referred, or others. If there is cause for immediate concern, staff will call the CCORS (ages 3 through 18) or the DMHPs (ages 13 and above and unwilling to accept voluntary service). If there is no immediate concern for safety, staff will proceed with the call.

7. **Determine if the caller or person referred is receiving any KCMHP services**.

    a. If so, staff will refer to the provider no later than close of business of the current day or if outside of usual business hours, no later than the start of business of the next working day.

    b. If not, staff will determine whether or not a face-to-face assessment is required.

8. **Determine if the situation requires a face-to-face assessment.** If not, staff will try to resolve the problem or refer to an appropriate provider. If the situation requires a face-to-face assessment, the following criteria and steps will apply:

    a. If the caller or person referred is 3 through 18 years of age and is not currently authorized for an outpatient level of care benefit, staff will call the CCORS.

    b. If the caller or person referred is 18 through 59 years of age, staff will determine if an in-facility or an outreach assessment is needed. If the caller or individual is unwilling to accept crisis services, or if there is a clinical reason for outreach, or if the individual referred requests/prefers an outreach, staff will call the DMHPs.

    c. If the person is 60 or older and meets the following criteria, staff will call GRAT:

        i. Is physically and/or medically compromised;

        ii. Is physically disabled;

        iii. Is lacking in family/friends able and willing to provide the support necessary to ensure health and safety;

        iv. Involuntary detention is imminent;

        v. Is refusing services; and

        vi. Requires an assessment for differential diagnosis.

    d. For all other situations, staff will arrange for a next-day appointment (NDA; for adults) or a non-emergent outreach (NEO; for children and youth) with the appropriate provider according to NDA minimum requirements in Attachment B.

    e. If the individual wishes to walk-in to a provider during business hours, the individual will be advised of that option. Staff will alert the provider to the individual's intention to walk-in and shall make every effort to get a phone number where the caller can be reached for follow-up. Providers shall use this information when available and as clinically indicated, to follow up on individuals who do not come in as expected.

Next-Day Appointments (NDAs) and Non-Emergent Outreach (NEOs) Minimum Requirements for Crisis Response System

Purpose:
To define the minimum requirements for scheduling face-to-face next-day appointments (NDAs) or Non-Emergent Outreach (NEOs for children and youth) for the adult and child designated mental health crisis services providers and to describe the expected response when a referred person fails to keep a NDA or NEO.

Requirements:
All NDA or NEO referrals shall go through the Crisis Clinic. The Crisis Clinic will maintain a listing of available appointment times for each crisis services provider. Appointments will be available for each day of scheduled operation in locations accessible for residents throughout King County.

Criteria:
The "Standardized Initial Crisis Screening Protocol (SICSP)" (see Section V, Attachment A) is used to determine if the caller or person referred requires a NDA or NEO.

Procedures:
Following are the procedures for scheduling next-day appointments and for following up when clients do not show up for their scheduled appointments.

If a determination is made to refer to a NDA or NEO, the following steps shall be taken:

1. The Crisis Clinic shall gather background information on the caller or person referred. In the case of a referral from a Designated Mental Health Professional (DMHP) or the Children's Crisis Outreach Response System (CCORS), or the Mobile Crisis Team (MCT), the information gathered will be limited to the client's name and the DMHP, CCORS, or MCT staff member name. In the case of a referral from a Mental Health Professional (MHP) in a hospital Emergency Department, a brief screening guide will be used.
2. The Crisis Clinic shall determine which crisis services provider is located closest to the caller or person referred.
3. The Crisis Clinic shall consult the book of available NDA or NEO times for each crisis services provider to determine an appointment time. If there are no available NDAs or NEOs at the provider located closest to the caller or person referred, the Crisis Clinic shall determine which remaining crisis services providers have available appointments and schedule the person into one of those.
4. On the morning of each day a provider's crisis service is open, –The Crisis Clinic will communicate the NDA or NEO referral information to the provider via phone of fax. If an appointment time is not scheduled by the time the provider receives the referrals for that day, the provider may plan to use that time for other purposes.
5. The Crisis Clinic will share all information gathered with the provider receiving the referral. In the case of a DMHP, MCT, or CCORS referral, the DMHP, MCT or CCORS shall call the appropriate crisis services provider with the necessary information.

If the person referred for the NDA or NEO fails to keep the appointment, the following steps shall be taken:

1. If the referred person **has not** been seen face-to-face by the DMHPs or CCORS:
   a. The Crisis Clinic will relay to the crisis services provider any information about the seriousness of the situation obtained during the telephone call.
   b. If the person has a telephone, the crisis services provider will call the person and reassess the need for crisis services. The SICSP will be used to determine whether the person needs a DMHP or CCORS outreach, an in-facility appointment, or a letter.
   c. If the person is inaccessible by or does **not** have a telephone, the crisis services provider will review all available information and make a determination about further follow-up. Factors to be considered include:
      1) History and immediacy of threats of harm to self and/or others;
      2) Access to weapons or other means of harm;
      3) Specificity of any plan for harm;
      4) History of substance abuse, including tobacco use;
      5) Adequacy of the support system;
      6) Psychotic features;
      7) Evidence of escalating behaviors;
      8) Issues of grave disability;
      9) Level of decompensation;
      10) Mobility; and
      11) Medical issues.
   d. If follow-up is indicated, the crisis services provider will use the SICSP to determine if an outreach is indicated and if so, whether the outreach should be provided by the provider or the DMHP or CCORS. If an outreach is not indicated, the provider may follow-up by notifying the person by mail that in-facility services are available. The letter will request that the person contact the provider if he/she would like follow-up. If no follow-up is indicated, the provider will close the case.
2. If the person referred **has** been seen face-to-face by the DMHPs or CCORS:
   a. When the DMHP or CCORS staff calls the crisis services provider with the NDA information, he/she will discuss the plan for no-shows;
   b. If the plan is for DMHP or CCORS follow-up, the crisis services provider will refer back to the DMHP or CCORS;
   c. If there is no specific plan for DMHP or CCORS follow-up, the crisis services provider will make decisions about appropriate follow-up using the SICSP. If an emergency outreach is indicated, the provider will refer back to the DMHP or CCORS. If a non-emergency outreach is indicated, the provider will do the outreach.

King County

Intensive Stabilization Services (ISS)
Referral Form

Date: _____ Time: _____ Referred By: _____
Agency: _____ Phone: (_____) _____
Referent's e-mail: _____ Fax Number: _____
Has family been informed that a referral to ISS was made? ☐ Yes ☐ No

Thank you for making a referral to the CCORS Intensive Stabilization Services Program. ISS is an intensive, in-home service for children, youth, and families where the functioning of the child and/or family is significantly impacted due to family conflict resulting from emotional or behavioral problems and where the current living situation is at risk of disruption or in need of immediate stabilization. Once enrolled in ISS services, families should expect to work frequently with the CCORS staff on skill building and behavioral management as well as other priority needs identified by the family.

Mental Health Clinicians and DCFS Social Workers are expected to be an integral part of the team throughout the ISS process and are *required to be actively involved* with the CCORS team during the course of ISS interventions. Treatment provided by Mental Health Clinicians is *expected to continue* during the course of ISS services.

Referral Goals:
☐ Hospital Diversion ☐ Placement Prevention ☐ Stabilize Living Arrangement

---

Child's Name: _____ ☐ M ☐ F
DOB: _____ Age: _____ Race/Ethnicity: ☐ Caucasian ☐ African American
☐ Hispanic ☐ Asian ☐ Native American ☐ multi-racial Other: _____
Tribe: _____ Language: _____ Parent Language: _____
Child's Address: _____ Apt. #_____
City: _____ Zip: _____ Phone: (_____) _____
Current Location: ☐ ER ☐ Home ☐ Other _____

Legal Status:
☐ Parental Custody ☐ VPA ☐ Guardianship ☐ State Dependent ☐ Protective Custody
☐ Shelter Care

Residential Arrangement:
☐ Home ☐ Relative Placement ☐ Foster Home ☐ Jail/Corrections ☐ Homeless
☐ Group Home ☐ Hospital ☐ Pre-adoption Home

Whom does the child live with? _____ Adopted? ☐ Yes ☐ No
Name/Relationship: _____ Work/Cell Phone: (_____) _____
Others in household: _____
Who is legal guardian? _____

Family Members:
Parent/Guardian: _____ Age: _____ Lives at Home? ☐ Yes ☐ No
Parent/Guardian: _____ Age: _____ Lives at Home? ☐ Yes ☐ No
Sibling's Name: _____ Age: _____ Lives at Home? ☐ Yes ☐ No
Sibling's Name: _____ Age: _____ Lives at Home? ☐ Yes ☐ No
Sibling's Name: _____ Age: _____ Lives at Home? ☐ Yes ☐ No

Describe Immediate Crisis Concerns/Behaviors:

Describe expected stabilization goal(s):

☐ **Attach Current Crisis or Safety Plan**

Current/Immediate Safety Concerns:
Suicidal Plan _____ Means Available ☐ Yes ☐ No
Homicidal Plan _____ Means Available ☐ Yes ☐ No
* Is there access to a weapon? ☐ Yes ☐ No If yes, explain: _____
Home Environment: _____
Safety Plan: _____
Psychotic Indicators: _____
Self-mutilation: _____
Onset of acuity: _____
Current Medications: _____

☐ **Significant Changes in Functioning (past 30 days)**
Appetite: _____
Sleep: _____
Self care: _____
Support systems: _____
Destructive to property: _____
Physical Aggression: _____

☐ **Current Mental Health Involvement**: Last Contact with MH Provider: _____
Mental Health Agency: _____ Tier Benefit: _____
Mental Health Therapist: _____ Phone: _____
Current Diagnosis: _____
Focus of Treatment Plan (top 3 goals):
1._____
2._____
3._____
Prescribed Treatment Modalities /Frequency: ☐ IT ____ ☐ FT _____ ☐ Group_____ ☐ Meds _____
Are the youth &/or family actively engaged in treatment? ☐ Yes ☐ No If no, explain:

Past suicide attempts: (method/dates): _____
Past Psychiatric Hospitalization (location/dates): _____
Past outpatient treatment (location/dates): _____
Past Assaultive Behavior: _____
Psychiatric Medications: (type/dose)_____
_____
Psychiatrist/prescriber: _____ Phone: _____
Insurance Status: ☐ Private ☐ Medicaid ☐ Other: _____ ☐ No Insurance

Other System Involvement:
Primary Care Physician: _____ Phone: _____
Current Physical Health Issues: ☐ Yes ☐ No If Yes, what? _____

☐ **Current Wraparound Involvement:**
Facilitator & Agency**:** _____Phone: _____
Next Wraparound Child & Family Team meeting**:** _____

☐ **Current Substance Use/Abuse/Treatment:**
Alcohol ☐ Quantity/Frequency _____
Street drugs ☐ Type: _____ Quantity/Frequency _____
Prescription drugs ☐ Type: _____ Quantity/Frequency _____
Present/Past Treatment Provider (location/dates): _____

☐**Current DCFS Involvement**:
DCFS Social Worker: _____ Phone: _____
DCFS Social Worker Supervisor: _____ Phone: _____
Office: ☐ King East ☐ King South ☐ King West ☐OICW ☐White Center ☐MLK ☐ Central/Permanency
DCFS Program: ☐ Child Protective Services (CPS) ☐ Child and Family Welfare Services (CFWS)
☐ Family Reconciliation Services (FRS) ☐ Family Voluntary Services (FVS)
Current Services being provided: _____
☐ **Attach Current Safety Assessment**

☐**Current Juvenile Justice Involvement:**
Assigned JPC: _____ Phone: _____
ARY/CHINS ☐ Truancy ☐ Offender: ☐ Charges: _____

☐**School Name**: _____ Grade: _____
School Attendance: ☐ Enrolled ☐ Suspended ☐ Not Enrolled ☐ Other Is child on SSI? ☐Y ☐N
School Contact Person: _____ Phone: _____

Impairments:
☐ Development/Intelligence ☐ Physical ☐ Sensory/Communication ☐ Other: _____
☐Hearing ☐ Vision ☐ PDD/Autism Spectrum

Please use additional pages as necessary.

Mental Health Referrals fax to MHCADSD (206) 205-1634
Attention: Sandy Tomlin

DCFS Referrals Fax to CA Region 2, South (206) 639-6271
Attention: Marschell Baker

For King County / Children's Administration Use Only:

King County MHCADSD Approval: ☐ Yes ☐ No Date: _____

_____
Sandy Tomlin, LICSW
Wraparound Program Specialist
MHCADSD

Children's Administration Approval: ☐ Yes ☐ No Date: _____

_____
Marschell Baker, MSW
BRS Regional Program Consultant
DSHS Children's Administration Region 2 South

VI. OUTPATIENT SERVICES LEVEL OF CARE

1.0 POLICY TITLE: CARE MANAGEMENT FOR OUTPATIENT SERVICES WITHIN THE MENTAL HEALTH PLAN (MHP)

1.1 Originally Implemented: April 1, 1995

1.2 Reviewed and revised: November 2014

1.3 Officially Adopted: January 2, 2015

1.4 Effective Date: February 2, 2015

1.5 Signed: _____
Jean Robertson, Assistant Division Director/RSN Administrator

2.0 PURPOSE: To describe the authorization of outpatient services level of care within the King County Mental Health Plan (KCMHP), including the crisis services to be provided to persons authorized to receive an outpatient benefit.

3.0 POLICY/PROCEDURES/RESPONSIBILITIES FOR ACCESS TO SERVICES:

3.1 Financial Eligibility

3.1.1 Medicaid Eligibility

A. Case rate authorizations that are approved (status AA and TM) are evaluated for Medicaid eligibility throughout the authorization period and 6 months beyond the expiration date. Current ProviderOne data is used to determine a client's Medicaid eligibility. For the purposes of the KCMHP a client is Medicaid eligible when "King County RSN – Mental Health Services Only" is identified in the "Managed Care Information" section of the ProviderOne portal.

The Medicaid eligibility status in the MHCADSD IS will match ProviderOne with three exceptions:

1. Clients in foster care of a confidential address.

   A client in foster care or a confidential address program will be considered King County RSN Medicaid eligible if the provider indicates that the client is in this type of program and if the client qualifies for RSN coverage in another RSN.

2. Clients living in border zip codes.

   Special processing is in place for cases where the client lives in a border zip code – these are zip codes that belong to two different counties (see Attachment P). When determining Medicaid coverage, we first check the residency information provided by the agency. If the agency reports the client does not live in King County, they will not be

considered Medicaid eligible. If the agency reports the client lives in King County, we will check our ProviderOne data to see if the client shows RSN coverage for another county. If the client does have RSN coverage for another county (and the agency indicates they live in King County) they will be considered Medicaid eligible.

3. Clients moving to King County mid-month.

   This exception applies to new authorization requests that are on hold (in UA status) due to a discrepancy between agency and ProviderOne Medicaid eligibility data. If a client moves to King County mid-month, that month will never show King County as the RSN in the ProviderOne system. To address this, we will apply the following month's RSN coverage to the previous (partial) month. In order for this to happen:

   a. The agency must indicate that the client lived in King County in the partial month;

   b. There must be King County RSN coverage for the first full month; and

   c. There must be non-King County RSN coverage for the partial month.

B. Effect of Change in Medicaid Coverage

1. Authorizations that started as Medicaid-funded

   a. Loss of Medicaid coverage: Payments for months without Medicaid coverage are suspended (resulting in a negative adjustment). Note when a client loses Medicaid coverage, payments are suspended, but the authorization is not cancelled, even if there is no coverage for the first month of the authorization.

   b. Gain of Medicaid coverage: Payments for months that are now covered, but were previously suspended, are reinstated (resulting in a positive adjustment).

2. Authorizations that started as non-Medicaid funded

   a. Loss of Medicaid coverage: There is no effect on payments.

   b. Gain of Medicaid coverage: A payment adjustment is made to reflect the change in funding source. The adjustment will only affect the payment amount if there is a difference between Medicaid and non-Medicaid case rates.

3. Discrepancy between agency and ProviderOne data

   When an authorization request is received we compare the agency-supplied Medicaid coverage data with the ProviderOne-supplied Medicaid coverage data. If there is a discrepancy, the authorization will not be approved and will be placed on hold. While the authorization is on hold, the discrepancy will be re-evaluated each time we receive updated ProviderOne data (typically on a daily basis). If the discrepancy is resolved, the authorization will be approved. If the discrepancy remains through the end of the month following the month of the authorization start date, the authorization will be cancelled.

C. The provider shall verify and document the person's Medicaid eligibility when accepted into services and monthly thereafter. For a person who receives services less than once a month, verification shall occur at each service contact. A person receiving both Medicaid and Medicare shall be eligible for KCMHP services as a Medicaid client who has a third-party resource.

3.1.2 Medicare Eligibility

Persons receiving Medicare (but not Medicaid) are eligible as persons not covered by Medicaid who have a third-party resource. A person with Medicare and a Qualified Medicare Beneficiary or Specified Low-income Medicare Beneficiary Medicaid is one of the priority populations to receive non-Medicaid service.

3.1.3 Non-Medicaid Eligibility

A. A person not covered by Medicaid who is a resident of King County may be eligible for an outpatient benefit if:

   1. The person meets financial eligibility criteria:

      a. Eligible children are those persons younger than 18 who have a family income of less than 300 percent of the federal poverty level;

      b. Eligible adults are those persons age 18 or older who have a family income of less than 200 percent of federal poverty level; and

      c. A person with health insurance that appears to cover the persons care needs may be denied a non-Medicaid benefit even when resources are available.

   2. The person meets clinical eligibility criteria and priorities.

B. Actual authorization to an outpatient benefit is dependent upon the availability of KCMHP financial resources.

C. A person with health insurance that appears to cover the persons care needs may be denied a non-Medicaid benefit even when resources are available.

3.2 Medical Necessity

3.2.1 All persons must meet the State's DSHS Access to Care criteria (see Attachment A, Access to Care Standards for the State document defining these standards).

A. Persons for whom a child authorization is being requested must meet the criteria for children.

B. All others must meet the criteria for adults.

3.2.2 The Access to Care criteria includes the following:

A. The person must have a mental illness diagnosis that is included in the list of covered diagnoses. Covered diagnoses are divided into two groups for each age group. An "A" diagnosis alone always meets medical necessity. A "B" diagnosis will meet medical necessity when other criteria are also met (see Section XII: Information Management, Attachment B for a list of A and B diagnoses);

B. The person's impairment(s) and corresponding service need(s) must be the result of the covered mental illness;

C. The proposed services are deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness;

D. The person is expected to benefit from the services;

E. The person's unmet need cannot be more appropriately met by any other formal or informal system or support;

F. The person must demonstrate moderate to serious functional impairment in at least one life domain requiring assistance and have a Global Assessment of Functioning or Children's Global Assessment Scale score of no more than 60;

G. Children under six years of age must have a severe emotional abnormality in their overall functioning as indicated by one of the following:

1. Atypical behavioral patterns as a result of an emotional disorder or mental illness (e.g., odd, disruptive, or dangerous behavior which is aggressive, self-injurious, or hypersexual; a display of indiscriminate sociability/excessive familiarity with strangers); or

2. Atypical emotional response patterns as a result of an emotional disorder or mental illness which interferes with the child's functioning (e.g., inability to communicate emotional needs, inability to tolerate age-appropriate frustrations, a lack of positive interest in adults and peers or a failure to initiate or respond to most social interaction, fearfulness or other distress that doesn't respond to comfort from caregivers);

H. Children age six or older, whose sole eligible diagnosis is a B diagnosis, must meet one of the additional criteria listed in Attachment B, Additional Criteria for Diagnosis B for Children; and

I. Adults or older adults whose sole eligible diagnosis is a B diagnosis must meet one of the additional criteria listed in Attachment C, Additional Criteria for Diagnosis B for Adults and Older Adults.

3.2.3 Documenting and reporting diagnoses

A. For all clients ages six and older: the provider must use "The Diagnostic and Statistical Manual (DSM) of Mental Disorders, Fourth Edition, Text Revision" (DSM-IV-TR) diagnoses.

B. For clients up to age six: the provider may use a DC03 diagnosis instead of DSM-IV-TR. However, the crosswalk tables in the Data Dictionary must then be used to crosswalk the DC03 diagnoses to DSM-IV-TR codes.

C. Justification for all diagnoses must be provided in the agency records. Documentation must include the date each diagnosis was made, the name and credential of the clinical staff person making the diagnosis, and the diagnostic criteria met by the client's condition that justifies the diagnosis.

D. Agency records must clearly identify, preferably in a single location, all diagnoses considered current for the individual client. These current diagnoses:

1. Must be age-appropriate;

2. Must not be mutually exclusive, per DSM-IV-TR criteria;

3. Must be considered accurate by all staff persons providing clinical treatment to the client. When this is not the case, the agency must conduct a process that resolves any differing opinions; and

4. May contain diagnoses under consideration. However, when these diagnoses have not been reported to MHCADSD IS because full criteria have not yet been met, this should be so indicated.

E. In all cases, the diagnoses must accurately include:

1. All diagnoses made by the agency medical staff; and

2. All substance use disorder diagnoses applicable to the client.

F. An agency must report at least one Axis I or Axis II diagnosis but no more than five Axis I and/or two Axis II diagnoses.

G. Whenever any Axis I or Axis II diagnosis is corrected or changed, the agency must resubmit all applicable current Axis I and Axis II codes. The most recent set of diagnoses is considered the correct and complete set of diagnoses for the client.

H. See the Data Dictionary section on Diagnoses for additional detail on the reporting of diagnoses information to MHCADSD IS.

3.2.4 Persons with Washington Apple Health who do not qualify for KCMHP services but may qualify for services through their Washington Apple Health provider shall be referred to that provider and given additional assistance as needed to facilitate the referral.

3.2.5 Priorities for persons who do not have Medicaid ("non-Medicaid")

A. The following table describes first and second priority populations for the use of non-Medicaid resources for routine outpatient benefits.

Criteria	First Priority	Atta D	Second Priority	Atta D
State Hospital Discharge	• Being discharged from Western State Hospital (WSH) within next 60 days or was discharged within last 30 days; • A Medicaid application is pending; and • Referred by adult hospital liaison.	X		
	• Being discharged from Children's Long-term Inpatient Facility within next 60 days or was discharged within last 30 days; and • A Medicaid application is pending.	X		
Release from Incarceration	• Will be released from WA State prison (except ORCSP/CIAP/ DMIO), or juvenile rehabilitation facility within next 30 days or was released within last 30 days; and • CGAS/GAF score less than 51; and • A Medicaid application is pending.	X		
Extraordinary Treatment Plan	• Person has a current non-Medicaid outpatient benefit; and • Is receiving Extraordinary Treatment Plan funds.	X		

Criteria	First Priority	Atta D	Second Priority	Atta D
Housing	• Person is residing in KCRSN SSH or ISH program or Shelter-Plus Care; and • Will lose housing if mental health services are not continued; • Person is residing in KCRSN LTR or SL facility; and • Is stepping down to the SSH program.	X		
Community Inpatient Hospital Discharge (includes E&Ts)	• Being discharged within next 30 days or was discharged within last 30 days from inpatient stay; and • Person has any diagnosis made by the hospital listed in Attachment E, Non-Medicaid Access Diagnosis Codes.			
			• Or, discharge is within next 30 days; • Person has any diagnosis made by the hospital listed in Attachment E, Non-Medicaid Access Diagnosis Codes; • A Medicaid application is pending; and • Hospital discharge social worker has received pre-approval from MHCADSD clinical specialist prior to discharge.	X
			• Or, see below on Frequent Admissions/ Detentions/Incarcerations	
Chronically Homeless			• Person is chronically homeless (see Definitions); and • CGAS/GAF score is less than 51.	X
Discharge from PACT	• Person is being discharged from PACT within the next 60 days; and • Has received prior approval by the MHCADSD PACT Committee. • A second year of benefits may be authorized, totaling two years of benefits since discharged from PACT.	X		X
3B for All Ages			• CGAS score is less than 41; or • GAF score is less than 31; and • Being referred for 3B case rate.	

Criteria	First Priority	Atta D	Second Priority	Atta D
3A for Children and Older Adults			• Children; or • Older adults; and • Meet criteria for 3A case rate.	
Refugees, Immigrants, and Their Children			• Refugees, or • Immigrants, or • Children of refugees or immigrants, and • CGAS/GAF score is less than 51.	
Medicare Qualifiers			• Qualified Medicare Beneficiary (QMB); • Specified Low-Income Medicare Beneficiary (SLMB); • Qualified Individual (QI-1) Medicaid benefit; and • CGAS/GAF score is less than 51.	
Current Non-Medicaid Benefit with Medicaid Application Pending			• Currently enrolled in a non-Medicaid benefit; • Not enrolled in a non-Medicaid benefit prior to current benefit; • Does not meet other non-Medicaid eligibility conditions; and • Has a Medicaid application submitted but not yet approved.	X
Frequent Admissions/ Detentions/ Incarcerations			• Person has had at least two admissions to any single resource or two admissions to any combination of the resources below within the year previous to the referral date: 1. Psychiatric inpatient – any inpatient stay authorized through the KCMHP. 2. Jail/youth detention – any stay that is recorded in a KC Department of Adult and Juvenile Detention database. • CGAS/GAF score is less than 51. • Referrals from Youth Detention must be made by the children's justice liaison. • Referrals from the KC Correctional Facility must be made by the MH Court Liaison.	
			• Referral from a suburban city jail by a criminal justice liaison. • Person meets the above frequent use criteria. • CGAS/GAF score is less than 51.	X

B. The following table describes the enhanced criteria for second priority populations, implemented as a pilot in September 2012. These shall be in effect until further notice.

Criteria	Second Priority	Atta D
Single Admission/ Detention/Incarceration (Pilot)	• Person has been admitted to psychiatric inpatient services or jail or youth detention; • Has a CGAS or GAF of less than 51; • Admission occurred in the 12 months prior to the authorization request date. [Requirement for two admission events in the previous 12 months reduced to one event]	
3A for all Ages (Pilot)	• Person meets the criteria for a 3A case rate. [Expanded to adults and not just children and older adults]	
Homeless (Pilot)	• Person is homeless according to the dictionary definition of homeless under the residential arrangement code; • Has a CGAS of GAF of less than 51. [Requirement that a person is "chronically" homeless has been removed]	

C. All authorization requests must be made electronically.

1. For agencies that get a quarterly allocation, the above table indicates when Attachment D-1 must also be submitted.

2. Agencies without a quarterly allocation must submit Attachment D-2 for all non-Medicaid benefit requests.

D. Second priority benefits are funded as resources permit.

E. For agencies that get a quarterly allocation, first priority benefits can be funded using the allocation or using the KCRSN Clinical Specialist's non-Medicaid fund source, at the discretion of the agency.

F. For agencies without a quarterly allocation, both first and second priority benefits are drawn from the KCRSN Clinical Specialist's non-Medicaid fund source.

3.3 Authorization for the outpatient level of care

3.3.1 Outpatient benefit package characteristics

A. Outpatient services are authorized for 12 months at a time.

B. During the 12-month benefit, the full array of outpatient services described below shall be available to the client, according to need and mutually negotiated goals of treatment.

C. A case rate of 2X, 3A, or 3B (most intensive) will be assigned to each outpatient benefit. The case rate determines the provider payment for this benefit and does not determine the array or amount of services the client will receive over the course of the benefit.

D. For the clinical criteria for the assigning of a case rate, see Attachment F, Clinical Case Rate Criteria; Attachment G, Clinical Case Rate Decision Tree; and Attachment H, Assessment Scales.

E. A provider may request a case rate change at any point in the benefit period when there has been a catastrophic and permanent change in the condition of the client. When such a request is granted, the duration of the outpatient authorization will be calculated based on the date of assessment.

3.3.2 Authorization requests are submitted electronically. See 5.0 INFORMATION SYSTEMS BUSINESS RULES below for a description of this process.

3.4 Timelines for authorizations and initiation of services

3.4.1 Intake Appointment

A. An intake appointment shall be offered within 10 working days of the request for mental health services to all persons covered by Medicaid and to all persons not covered by Medicaid who meet financial eligibility and are First Priority. When resources are available for persons not covered by Medicaid who are Second Priority, this timeline also applies.

1. A request for services is the point in time when a person legally authorized to sign the consent for treatment seeks care by scheduling an appointment for an intake for routine mental health services through a telephone call, walk-in, written request, or the receipt of a written Early Periodic Screening, Diagnosis, and Treatment (EPSDT) referral. An EPSDT referral is only a request for service when an individual or the person legally authorized to sign for consent for treatment for that individual has confirmed that he or she is requesting service.

2. Exceptions to this requirement are:

a. The caller is a staff person on an inpatient psychiatric unit and this person reports that the attending psychiatrist has not diagnosed the person with a covered diagnosis;

b. The person has called the agency in error, in that the person is requesting a service that the agency does not provide, is not requesting mental health services, and is not indicating in any way that he/she is someone who in fact needs mental health services; and

c. The person is not covered by Medicaid and KCMHP financial resources are not available to pay for all or part of the person's care.

B. Providers may screen requests over the phone and give a person an indication of the likelihood of his or her meeting Access to Care criteria.

C. If the person declines an intake appointment within the first 10 working days following a request, the provider must document the reason.

D. Whenever a person covered by Medicaid or a person designated as a First Priority not covered by Medicaid requests mental health services and an intake evaluation is not offered, or the person meets medical necessity criteria but an authorization is not requested, the provider must inform the KCMHP so that a Notice of Action or Notice of Determination can be sent. (See Section III: Client Rights, Attachment H.)

E. When non-Medicaid resources are available, the provider must similarly inform the KCMHP when a person, based on a screening phone call, referral information, and/or a brief face-to-face visit, appears likely to meet the criteria for a non-Medicaid benefit as a Second Priority client but is not offered an intake or the person is determined through an intake to meet medical necessity criteria but an authorization is not requested.

3.4.2 Authorization requests

Authorization requests shall be submitted by the provider as expeditiously as the client's health condition requires and no later than nine calendar days after the intake was initiated.

3.4.3 Authorization decisions

A. MHCADSD IS will provide electronic notice of all authorization decisions to the provider within 24 hours of receipt of an electronic request for authorization. See 5.0 INFORMATION SYSTEMS BUSINESS RULES below for a description of this process.

B. The time frame for authorization decisions may be extended up to 14 additional calendar days if:

1. The client, or the provider, submits to KCMHP Client Services a request for an extension within 14 calendar days of the request for service; or

2. KCMHP justifies to the state DSHS upon request a need for additional information and how the extension is in the client's interest.

C. KCMHP will monitor the use and pattern of extensions and apply corrective action where necessary.

3.4.4 Initiation of routine services

A. Receipt of an electronic notice of authorization for services by the provider from MHCADSD IS means that medical necessity for a client has been met and:

1. The first routine appointment must be offered to occur within 28 calendar days of request for service;

2. The first routine appointment must be offered regardless of whether or not the requested case rate as described herein has been determined; and

3. The first routine appointment may be provided prior to the completion of the intake.

B. Should the provider submit information that is incomplete or improperly submitted regarding a client who is covered by Medicaid who meets medical necessity criteria, the provider shall still initiate medically necessary services according to the above timeline while the data submission problems are corrected.

C. Authorization requests regarding a client who is covered by Medicaid who meets medical necessity criteria that are "pended" in order to undergo a 3B review are considered authorized to the outpatient level of care.

1. The 3B review determines the case rate payment amount for the authorized outpatient benefit.

2. The provider shall initiate medically necessary services according to the above timeline while the 3B review is completed.

D. If the client declines an appointment offered within the 28-day timeline following a request for service, the provider must document the reason.

If there is a delay by the provider that results in routine services not being offered to begin within 28 calendar days of the request for mental health services to a client who meets medical necessity requirements and who has received an intake, the provider must inform the KCMHP and document the reasons for any delay.

E. If a provider decides not to offer routine services to an eligible Medicaid client who meets medical necessity criteria, the following shall occur:

1. A written justification, specific to that agency and that client and accompanied by appropriate documentation, must be submitted to KCMHP Client Services within three working days of the intake;

2. Should KCMHP Client Services determine that the submitted justification is not sufficient to deny the client his/her choice of agency: the provider shall commence care within the required time frame; and

3. If no KCMHP provider is able or willing to serve the client, the KCMHP will purchase services outside the provider network.

F. KCMHP will monitor the frequency of routine appointments that occur after 28 days for patterns and apply corrective action where needed.

3.4.5 Expedited authorizations and services

A. If the provider indicates or KCMHP determines that following the standard timelines could seriously jeopardize the client's life or health or ability to attain, maintain, or regain maximum function, the client shall be offered crisis services or scheduled for an intake evaluation on the next working day.

1. The provider shall submit an authorization request within two working days of the intake.

2. KCMHP must make an expedited authorization decision and provide notice as expeditiously as the client's health condition requires, no later than three working days after receipt of the request for service.

B. KCMHP may extend the three working day time period by up to 14 calendar days if the client requests an extension or if KCMHP justifies to the state DSHS, upon request, a need for additional information and how the extension is in the client's interest.

3.4.6 A client shall be offered, by the provider, a choice of mental health care providers (MHCP) (see Section III: Client Rights).

3.5 KCMHP clinical staff review of designated electronic authorization requests

3.5.1 KCMHP clinical staff will manually review the following requests, subsequent to their electronic submission:

A. All 3B case rate requests;

B. Catastrophic and permanent change requests;

C. Vendor change requests; and

D. Other flagged requests as determined by the KCMHP.

3.5.2 3B case rate requests and certain other more complex requests shall be reviewed individually by a KCMHP staff member who is a Mental Health Professional (MHP) as defined in Chapter 388-865 Washington Administrative Code (WAC) or its successor.

3.5.3 Outpatient authorization changes, case rate changes, or terminations may be made by the KCMHP as the result of any clinical review.

3.5.4 KCMHP clinical staff shall do the following when a provider has requested a 3B case rate or made another request requiring manual review:

A. Within one working day after the request has been verified by the MHCADSD IS, KCMHP will review all current information in the data system and use the agency-designated single-point-of-contact number to contact the provider to request the required clinical information.

B. Required clinical information includes a recent assessment, the proposed individual service plan (ISP), copies of Attachments B or C when applicable, and, for continued stay, a previous benefit review.

1. The assessment must:

a. Clearly identify level of functioning in multiple settings, the client's symptoms, behaviors, frequency and severity of the behaviors, strengths, areas in which therapeutic intervention is recommended, and the areas for which the client has identified needs and goals;

b. Substantiate the level of functioning score; and

c. Be current.

2. The proposed ISP:

a. Must indicate both immediate and long-range interventions;

b. Must recommend services that are feasible, efficient, timely, and justify the requested case rate as specified in Attachment I, Checklist for Case Review of this Section;

c. Must include goals and objectives that are specific, measurable, achievable, reasonable, and time-delineated (SMART);

d. Shall emphasize the utilization of a wraparound process, using a child and family team for children with multi-system involvement, when seeking approval of a 3B case rate;

e. Does not need the client's signature at the time of submission to KCMHP for review. The client's involvement in the ISP, as required by WAC, will be reviewed during the contract compliance site visit; and

f. For clients who are receiving intensive behavioral health care services reimbursed by another funding source, the ISP shall clearly state which system is funding what services.

C. For a request for case rate change due to catastrophic and permanent change in client circumstances, the following additional information must be submitted for KCMHP clinical staff review:

1. A description of the change in circumstance; and

2. Medical reports to substantiate the above.

3.5.5 All required clinical information must be received by KCMHP no later than five business days after the initial KCMHP contact.

3.5.6 Once the documentation has been received, KCMHP clinical staff will review it to determine whether it supports the case rate request. This review will be completed within one business day.

If the clinical documentation supports the case rate request, the request will be approved and the provider notified through the daily MHCADSD IS report.

3.5.7 If KCMHP clinical staff is not able to make a determination based on the information submitted, KCMHP clinical staff will call the single-point-of-contact to request additional information. The provider must submit the requested information within three business days of the request.

3.5.8 When the additional requested information is received, KCMHP clinical staff will review it within three business days to determine if the documentation addresses the issues in question. If the additional documentation supports the request, the request will be approved and the provider notified through the daily MHCADSD IS report.

3.5.9 If the documentation does not support the request, KCMHP clinical staff will contact the clinical supervisor or clinical director for the required information. The provider must submit the additional information within three business days.

3.5.10 When the requested information is received, KCMHP clinical staff will review it within three business days to determine if the documentation addresses the issues in question.

A. If the documentation supports the request, the request will be approved and the provider notified through the daily MHCADSD IS report.

B. If the documentation does not support the request, KCMHP clinical staff will change the request to a case rate that the documentation does support and will use the provider's single-point-of-contact to inform the provider about the change, the reason the request was not approved, and the provider appeal process. (See 3.8 Provider Appeals below for procedures for the provider appeal process.)

3.5.11 If KCMHP clinical staff receives no clinical documentation by the due date(s), the request will be canceled and the decision documented in the Client Locator System (CLS). KCMHP clinical staff will use the provider's single-point-of-contact to inform the provider of the cancellation and the option to resubmit the request.

3.5.12 For case discussions with KCMHP clinical staff related to the approval review, the provider should be prepared to discuss any relevant issues from Attachment I, Checklist for Case Review.

3.6 Continuing Stay Criteria

3.6.1 Continuing stay criteria are the medical necessity criteria applied at the point that a new outpatient authorization is needed to continue mental health services. If the client is switching from a Medicaid-funded benefit to a non-Medicaid-funded benefit, a new authorization may be needed because of the expiration of the previous outpatient authorization or the termination of a previous benefit.

3.6.2 The assessment for meeting medical necessity criteria must involve face-to-face contact with the client.

3.6.3 Clients who have had an intake evaluation by a mental health professional for a previous outpatient authorization need not have the assessment for a next benefit performed by a mental health professional.

3.6.4 The continued stay criteria for outpatient services are as follows:

A. The client must have a mental illness diagnosis on the list of covered disorders in the state Department of Social and Health Services' Access to Care criteria. Covered diagnoses are divided into two groups for each age group. An "A" diagnosis always meets medical necessity. A "B" diagnosis will meet medical necessity when other criteria are also met. (See Section XII: Information Management, Attachment B for further detail about diagnosis reporting, including a list of A and B diagnoses);

B. The client's impairment(s) and corresponding need(s) must be the result of the covered mental illness;

C. The client has a current GAF or CGAS of 60 or below and at least moderate impairment in a life domain, or the individual's current symptoms and history demonstrate a significant likelihood of functional deterioration if mental health treatment is discontinued;

D. The proposed treatment is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness, and is provided in accordance with the KCMHP policies and guidelines;

E. The client is expected to benefit from the treatment;

F. The client's unmet need cannot be more appropriately met by any other formal or informal system or support; and

G. For a benefit funded by non-Medicaid dollars, additional non-Medicaid clinical criteria must be met [see Section 3.2.5 Priorities for persons who do not have Medicaid ("non-Medicaid") above].

3.6.5 The provider may submit a request for a new outpatient authorization when a client is nearing the end of the current outpatient authorization and demonstrates medical necessity for continued outpatient services.

3.6.6 The authorization request must not be submitted more than 31 days in advance of the expiration or termination date of the current authorization.

3.6.7 The provider must report an assessment date to the MHCADSD IS that falls within the 30 calendar days before the current authorization ends and that meets all assessment data requirements and timelines as described in Section XII: Information Management.

3.6.8 Continued Stay request procedures are the same as those for an initial authorization request.

3.6.9 For the 3B case rate and for other benefits as needed, the KCMHP clinical staff, following a review of the information below, will evaluate the effectiveness of services provided during the previous benefit and make any needed recommendations for changes in the ISP:

A. What was achieved or not achieved during the previous benefit period;

B. How the continued benefit is expected to build on these experiences; and

C. If the client has a history of low service episodes or hours, how and why the proposed service intensity is justified.

3.7 Termination

3.7.1 Termination of a benefit occurs when an authorization for services is ended prior to the original expiration date.

3.7.2 A terminated benefit is payable to the date of termination.

A. For the required terminations below, the date of the termination is the date of the event, unless otherwise specified.

B. When a required termination is not submitted or is submitted with an incorrect effective date, payment for the benefit beyond the correct effective date may be recouped.

3.7.3 A provider must submit to the MHCADSD IS a request to terminate a benefit under the following circumstances:

A. The client dies;

B. The client moves out of the County;

C. The client has been in the hospital [including state hospitals, community hospitals, or Children's Long-term Inpatient Programs (CLIP) facilities] for 30 days and will not be discharged within an additional 60 days. The effective date of the submitted termination must be 30 days from the date of admission. A new or continued authorization for outpatient services may be requested when a client will be discharged within 60 days. Note that whenever a client loses Medicaid eligibility, any requirements to terminate a benefit due to loss of eligibility also apply and may have taken effect before the requirement here can take place;

D. The client has been in prison, jail, Juvenile Rehabilitation Administration facilities, or juvenile detention for 30 days and release will not be occurring within an additional 30 days. The effective date of the submitted termination must be 30 days from the date of detention. A new or continued authorization for outpatient services may be requested when a client will be released within 30 days. Note that whenever a client loses Medicaid eligibility, any requirements to terminate a benefit due to loss of eligibility also apply and may have taken effect before the requirement here can take place; and

E. The client is enrolled in the Program of All-inclusive Care for the Elderly (PACE).

3.7.4 A provider may submit to the MHCADSD IS a request to terminate a benefit at any time based on significant changes in the client's clinical profile and needs. Reasons for this optional termination include:

A. Successful completion of the ISP where treatment goals have been met;

B. Inability to provide services to a client where factors other than those under the control of the provider make the provision of care impossible;

C. The client no longer meets outpatient level of care criteria and has been transitioned to and enrolled in an allied system. When appropriate, it is expected that the client will be referred and enrollment verified in another system for continued care; and

D. The client gains enough resources during the benefit to be treated as a private-pay client.

3.7.5 If a benefit is being terminated because a client is transferring to a new provider, the original provider must continue to provide services for the client until it receives an electronic notification of the termination of the benefit. The original provider shall not initiate termination of the benefit.

3.7.6 Unless specified above, the effective date of a termination shall be the date of the event leading to the termination.

3.8 Provider Appeals

3.8.1 Providers may appeal case rate decisions made by the KCMHP.

3.8.2 The appeal process has two stages: expedited review and appeal.

A. Expedited Review

1. Within 10 days after the decision was made, the provider shall request a review by the KCMHP Clinical Specialist.

2. The KCMHP Clinical Specialist may request the provider to send parts of the clinical record to support the appeal.

3. The KCMHP Clinical Specialist will review the decision and contact the provider within five working days.

4. If the provider is not satisfied with the results of the expedited review, the provider may file an appeal.

B. Appeal

1. An appeal must be expressed in writing to the KCMHP Medical Director within 10 working days of the expedited review. The appeal shall contain the following information:

   a. Client's name, KCID number, and the decision at issue;

   b. Sources of disagreement regarding the decision and the reason(s) for the request for further review; and

   c. All relevant sections of the clinical record.

2. For appeals, except those in which the client is receiving intensive behavioral health care services reimbursed by another funding source, the KCMHP Medical Director will base all decisions on the written documentation provided and will respond in writing with a decision within 10 working days from receipt of all information needed.

   a. The appeal decision may be based on factors beyond the original reason for denial.

   b. The KCMHP Medical Director's decision is final and binding.

   c. If the KCMHP Medical Director was involved in the previous decision, he/she will designate another psychiatrist to review the appeal.

3. For appeals involving a client who is receiving intensive behavioral health care services reimbursed by another funding source, the KCMHP Medical Director will convene the Appeal Review Group. The Appeal Review Group will consist of the Medical Director, the Cross-System Coordinator, and a KCMHP clinical staff person who was not involved in the initial decision or the expedited review.

    a. Decisions will be based on the written documentation provided. The appeal decision may be based on factors beyond the original reason for the decision.

    b. The Appeal Review Group will respond in writing with a decision within 10 working days from the receipt of all information needed.

    c. The Appeal Review Group's decision is final and binding.

C. Documentation

1. KCMHP will be responsible for documenting all decisions regarding expedited reviews and appeals.

2. KCMHP will send all appeal decisions in writing to the provider.

3. Any indicated changes to the data in the MHCADSD IS will be made by KCMHP.

3.8.3 KCMHP will track and monitor provider appeals at all levels of care for the purpose of quality improvements.

3.8.4 Providers will provide appropriate services to the client during the above appeal processes.

3.9 Notices for clients

3.9.1 Each client will receive notification from KCMHP should the following events occur:

A. Failure to offer an intake to a Medicaid client;

B. Following an intake, the provider determines that the client does not meet medical necessity criteria;

C. Following an intake, the provider does not request an authorization for a Medicaid person who meets medical necessity criteria, when KCMHP concurs with this decision;

D. Services are authorized;

E. Services are denied;

F. An authorization is terminated; or

G. In the rare event that KCMHP decides to reduce or suspend outpatient services previously authorized for a Medicaid client.

3.9.2 See Section III: Client Rights for additional information about client notification.

3.10 Client appeals

3.10.1 A client covered by Medicaid may appeal any decision in a Notice of Action. (see Section III: Client Rights).

3.10.2 Any client may grieve any decision in a Notice of Determination (see Section III: Client Rights).

3.10.3 The procedures for client appeals and grievances are in Section III: Client Rights.

3.11 Extraordinary Treatment Plan (ETP) approval requests

When a client has treatment needs that exceed the most service-intensive benefit within the KCMHP outpatient or residential levels of care, an ETP funding request may be made to the KCMHP.

3.11.1 ETP funds are to be used only for clients in the KCMHP outpatient or residential levels of care.

3.11.2 ETP-funded services must be needed to enable the client to safely maintain community tenure.

3.11.3 ETP funds shall be used to purchase clinical treatment services and supports and not equipment or supplies. ETP funds shall not be utilized to fund acute services (e.g., hospital diversion crisis beds, partial hospitalization, etc.).

3.11.4 ETP funds shall not be utilized to cover services that are by mandate or traditionally funded by allied systems.

3.11.5 ETP funds must be approved by KCMHP prior to the delivery of the services.

3.11.6 ETP requests will be approved for no more than 90 days at a time. Should an individual potentially need ETP resources beyond a 90-day period, a new request must be initiated prior to the end of the period that had been approved.

3.11.7 ETP funds are provided only as resources permit.

3.11.8 If a person who has been approved for ETP funding is non-Medicaid, the outpatient benefit authorization may be renewed as a non-Medicaid exception to policy.

3.11.9 Services provided to a client with ETP funds shall be documented and submitted electronically to the MHCADSD IS as services provided under the outpatient benefit authorization.

A. In the clinical record and in the ETP billing, a clear distinction must be made between services that are covered under the 3B case rate and ETP-funded services.

B. ETP services are billed separately to KCMHP for reimbursement.

C. Planned ETP services must be distinguished from planned 3B services in any ISP submitted for a 3B case rate approval.

D. Agencies receiving ETP funds will be audited periodically to ensure that ETP funds are used to provide the approved services, with adequate documentation, electronic submission of hours, and distinction from 3B services.

3.11.10 Requests for ETP funds are made as follows:

A. The provider clinician shall complete Attachment J: ETP Request Form. The form shall be submitted to the KCMHP by the provider medical director and clinical director and shall provide the following information:

1. The provider's assessment, including differential diagnosis, current medications, and exceptional need;

2. The proposed ISP, including:

a. How the service plan will modify or complement previous treatment;

b. Why the extraordinary treatment is essential to the client maintaining safe community tenure; and

c. How the interventions will lead to no longer needing ETP funds;

3. An explanation of why these goals cannot be met using the existing outpatient case rate.

a. The request shall demonstrate that the agency's clinical and medial directors have reviewed and concurred with the assessment and proposed treatment approach including the need for a request for ETP funds.

b. Letters from allied systems that indicate either their participation in funding or denial of funding responsibility for the ETP services.

c. When all services in an ETP plan will not be provided by the KCMHP provider submitting the request, the provider is expected to subcontract for the services it will not provide itself. All services must be provided by persons who are appropriately credentialed to perform the services identified in the plan and subcontractors must meet all KCMHP requirements.

d. A budget showing any contributions for care provided by other treatment systems. State what alternative sources of money have been explored (third-party, donations, Wraparound Team flex funds, learning grants, etc.), the amount received under the current approval, the exact amount needed, and the length of time for which these funds are being requested.

B. To request an extension of an ETP beyond the originally approved 90-day period, the provider clinician, in conjunction with the provider medical director and clinical director, shall provide to KCMHP an updated ETP Request Form prior to the end of the period that had been approved. The following information shall be provided:

1. A review of the services the individual received during the past 90 days and how these services have supported the individual's community tenure and progress toward treatment goals;

2. The current ISP with any additions or revisions including the individual's progress toward goals, need changes, and additional supports secured from allied systems. It must also demonstrate the continued need for the intensive supports of the ETP;

3. Letters from allied systems that indicate either their participation in funding or denial of funding responsibility for the ETP services, if the provider has sought participation of allied systems during the past 90 days; and

4. A revised budget showing any contributions for care provided by other treatment systems. The request must also state what alternative sources of money have been explored (third-party, donations, Wraparound Team flex funds, learning grants, etc.), the amount received under the current approval, the exact amount needed and the length of time for which these funds are being requested.

a. The KCMHP requires a minimum of 10 working days to consider each request.

b. The KCMHP may require a case staffing meeting to facilitate consideration and development of a disposition for the ETP request.

c. A written response shall be sent to the provider indicating approval, denial, or the need for more information.

d. The provider has the right to appeal a denial by submitting a letter for further consideration of the request. The request for RSN administrator appeal should be addressed to the Assistant Division Director within seven days of the denial.

4.0 POLICY/PROCEDURES/RESPONSIBILITIES FOR SERVICES:

4.1 Services

4.1.1 Services shall be provided according to all of the following values:

A. Cultural, linguistic, and disability competence;

B. Orientation towards promoting recovery and resiliency (see Section I: Purpose of the King County RSN); and

C. Appropriateness to the age and developmental stage of the client.

4.1.2 For all age groups, the following state plan modalities are available (see Attachment K: State Plan Modalities):

A. Brief intervention treatment;

B. Crisis services;

C. Day support;

D. Family treatment;

E. Group treatment services;

F. High intensity treatment. Programs offering high intensity treatment must be designated by KCMHP;

G. Individual treatment services, including psychotherapy and assistance with entitlements, protective payeeship, GED and post-secondary education;

H. Intake evaluation;

I. Medication management;

J. Medication monitoring;

K. Mental health services provided in residential settings;

L. Peer support, including parent-to-parent services;

M. Psychological assessment;

N. Rehabilitation case management;

O. Special population evaluation;

P. Stabilization services;

Q. Therapeutic psychoeducation.

4.1.3 The following are also available:

A. Interpreter services, including sign language interpretation and other services for clients who are sensory-impaired (see Section III: Client Rights);

B. Health screen referrals;

C. All authorized clients who have physical health needs must be referred to a qualified professional for a health screen if they have not been screened within the past year. For persons over the age of 60, a referral for screening shall be made if the individual has not been screened within the past 90 days. These referrals must be recorded in the client's chart;

D. Employment and vocational services for those of employment age (16-65 years of age), according to WAC 388-0865-0464 or its successor;

E. Residential and housing services, according to WAC 388-865-0235(3) or its successor;

F. Co-Occurring Disorder Screening and Assessment (see Attachment L);

G. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screenings for children and youth.

4.1.4 Intake Evaluation Requirements

A. Individuals of all ages who are eligible for community mental health outpatient services must have an intake evaluation to determine if:

1. A mental illness exists that is a covered diagnosis under Washington state's section 1915(b) capitated waiver program; and

2. There are medically necessary state plan services to address the individual's needs.

B. An intake evaluation is not required prior to the provision of:

1. Crisis services;

2. Stabilization services; or

3. Rehabilitation case management services.

C. The intake evaluation must:

1. Be performed by mental health professional, as defined in Revised Code of Washington (RCW) 71.05.020;

2. Meet the time frame requirements in Section 3.4.1, Intake Appointment;

3. Be initiated during the first intake appointment and completed within 30 working days of the intake appointment;

4. Be culturally, linguistically, age, and disability relevant;

5. Be conducted in person;

6. Include a brief problem and pathological gambling history;

7. Document sufficient information to demonstrate medical necessity as defined in the state plan (see Section 3.2.1, Medical Necessity, above), and must include:

    a. Presenting problem(s) as described by the individual, including:

        i. A review of any documentation of a mental health condition provided by the individual; and

        ii. Input from people who provide active support to the individual, if the individual so requests, or the individual is under 13 years of age;

    b. Current physical health status, including:

        i. If the individual has a medical provider and if he or she has been seen within the last year; and

        ii. Any medications the individual is taking;

    c. Current substance use and abuse and treatment status (GAIN-SS);

    d. Sufficient clinical information to justify the provisional diagnosis using Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) criteria, or its successor (see Section 3.2.3, Documenting and reporting diagnoses);

    e. An identification of risk of harm-to-self and others, including suicide/homicide;

        Note: A referral for provision of emergency/ crisis services, consistent with WAC 388-877A or its successor, must be made if indicated in the risk assessment;

    f. Whether the individual is under the supervision of the department of corrections; and

g. A recommendation of a course of treatment that:

i. Addresses the presenting problem; and

ii. Identifies the use of one or more state plan modalities.

4.1.5 Developmental Screening and Assessment

A. The Ages and Stages Questionnaires (ASQ) and The Ages and Stages Questionnaires: Social-Emotional (ASQ-SE) must be completed on all children ages 0 to 5 years of age in accordance with the ASQ and ASQ-SE User's Guide.

B. A developmental assessment must be completed for all children and youth ages 5 through 21 who are enrolled in a child outpatient benefit. The developmental assessment must include the child/youth's current functioning in the following domains:

1. Physical Growth and Development;

2. Cognitive Development;

3. Emotion Regulation;

4. Moral Development;

5. Sense of Self/Identity Formation;

6. Social Development;

7. Family Relationships; and

8. Sexual Identity Development (ages 13 and older).

C. The Developmental screening and assessment must be completed within 60 days of intake and annually thereafter.

4.1.6 Individual Service Plan (ISP) development and review

A. Development of the ISP must:

1. Be client-driven and strengths-based;

2. Meet the individual's unique mental health needs; and

3. Be developed in collaboration with the individual or with the individual's parent or other legal representative if applicable.

B. The ISP must:

1. Be initiated:

   a. With at least one goal identified by the individual, or their parent or other legal representative if applicable; and

   b. At the intake evaluation or the first session following the intake evaluation;

2. Have a goal to address the acquisition of appropriate housing for individuals who are homeless;

3. If the individual is of employable age and has an interest to explore and/or pursue vocational/employment activities, have a goal to address employment;

   (See Section 4.1.17, Vocational Services for more information about providing clients with vocational assistance.)

4. Be developed within 30 days from the first session following the intake evaluation;

5. Address age, cultural, or disability issues identified by the individual, or their parent or other legal representative if applicable, as relevant to treatment;

6. Include treatment goals or objectives that are measurable and that allow the provider and individual to evaluate progress toward the individual's identified recovery goals;

   a. Objectives shall:

      i. Be short-term steps to assist the individual to reach his/her goals;

      ii. Be specific, measurable, attainable, realistic and timely; and

      iii. Build upon identified individual, family and community strengths.

7. Be in language and terminology that is understandable to individuals and their family;

8. Identify medically necessary service modalities, mutually agreed upon by the individual and provider, for this treatment episode;

9. Demonstrate the individual's participation in the development of the ISP;

   a. Participation may be demonstrated by the individual's signature and/or quotes documented in the plan;

b. Participation must include family or significant others as requested by the individual; and

c. If the provider developing the plan is not a mental health professional, the plan must also document approval by a mental health professional;

10. Include documentation that the ISP:

a. Was reviewed at least every 180 days for all outpatient benefits except those paid with a 3B case rate;

i. The 180 day time period begins with the start of services date. Provider client records must document the date the ISP was developed, and the date of review;

ii. For 3B case rate, the ISP must be reviewed and updated at the 90th day and 180th day for the initial benefit, and then every 180 days for the remainder of that benefit and for subsequent contiguous benefits; and

iii. If a provider continues to serve an individual for an interval of time between benefits (so that benefits are not contiguous), the timing of the reviews may be adjusted so that routine reviews occur no more often than every 180 days, no matter when benefits begin or end;

b. Was updated to reflect:

i. Any changes in the individual's treatment needs or as requested by the individual, or their parent or other legal representative if applicable;

ii. An assessment of current strengths and needs; and

iii. Input from other health, education, social service, and justice agencies, as appropriate and consistent with privacy requirements;

11. Identify any changes that have occurred since the previous assessment (or intake). With the individual's consent or the consent of their parent or other legal representative if applicable;

a. Coordinate with any systems or organizations the individual identifies as being relevant to the individual’s treatment; and

b. This includes coordination with any individualized family service plan (IFSP) when serving children under three years of age; and

12. If an individual disagrees with specific treatment recommendations or is denied a requested treatment service, they may pursue their rights under WAC 388-865-0255 or its successor (see Section III, Client Rights, Section 4.6).

4.1.7 Clinical record content

A. The licensed community mental health agency must maintain a clinical record for each individual served in a manner consistent with WAC 388-877, or any successors.

B. The clinical record must contain, within 180 days of intake or sooner as needed or required:

1. An intake evaluation;

2. Evidence that the consumer rights statement was provided to the individual, or their parent or other legal representative if applicable (see Section III: Client Rights);

3. Documentation that the provider requested a copy of and inserted into the clinical record if provided, any of the following:

a. Mental health advance directives (see Section III, Advance Directives);

b. Medical advance directives (see Section III, Advance Directives);

c. Powers of attorney;

d. Letters of guardianship, parenting plans and/or court order for custody;

e. Least restrictive alternative order(s); and

f. Discharge summaries and/or evaluations stemming from outpatient or inpatient mental health services received within the last five years, when available;

4. Any crisis plan that has been developed (see Section 4.1.9, Crisis Plans);

5. The ISP and all revisions to the plan;

6. Documentation that services are provided by or under the clinical supervision of a mental health professional;

7. Documentation of any clinical consultation or oversight provided by a mental health specialist and his/her recommendations;

8. Documentation of:

    a. All service encounters (see Section 4.2.1);

    b. Objective progress toward established goals as outlined in the ISP; and

    c. How any major changes in the individual's circumstances were addressed;

9. Documentation that any mandatory reporting of abuse, neglect, or exploitation consistent with Chapters 26.44 and 74.34 RCW has occurred;

10. Documentation that the Department of Corrections was notified by the provider when an individual on a less restrictive alternative or Department of Corrections order for mental health treatment informs the provider that the individual is under supervision by the Department of Corrections;

    a. Notification can be either written or oral. If oral notification, it must be confirmed by a written notice, including e-mail and fax.

    b. The disclosure to Department of Corrections does not require the person's consent.

    c. If the individual has been given relief from disclosure by the committing court, the individual must provide a copy of the court order to the treating community mental health agency (CMHA).

    d. There must be documentation that an evaluation by a designated mental health professional (DMHP) was requested in the following circumstance:

        i. The mental health provider becomes aware of a violation of the court-ordered treatment of an individual when the violation concerns public safety; and

        ii. The individual's treatment is a less restrictive alternative and the individual is being supervised by the department of corrections;

11. Either:

    a. Documentation of informed consent to treatment by the individual or parent or other legal representative (See Section III: Client Rights); or

    b. A copy of the detention or involuntary treatment order if treatment is court ordered (See Section 4.1.14.B);

12. Documentation that the individual, or their parent or other legal representative if applicable, are informed about the benefits and possible side effects of any medications prescribed for the individual in language that is understandable;

13. Documentation of confidential information that has been released without the consent of the individual under the provisions in RCW 70.02.050, 71.05.390, 71.05.630, and the Health Insurance Portability and Accountability Act (HIPAA). (See Section XIII: Privacy and Security of Information Systems Data and Client Records, Attachment A, Protection of Confidential Client Information);

14. For individuals receiving community support services, the following information must be requested from the individual and the responses documented:

    a. The name of any current primary medical care provider;

    b. Any current physical health concerns;

    c. Current medications and any related concerns;

    d. History of any substance use/abuse and treatment, including tobacco use;

    e. Any disabilities or special needs:

       When developmental delays are identified in children and youth, include goals that focus on restoration to typical functioning;

    f. Previous history of use of inpatient or outpatient services and/or medications to treat a mental health condition; and

    g. Information about past or current trauma and abuse;

15. A description of the individual's strengths and resources, including:

    a. An inventory of the individual's and family's (when appropriate) strengths and needs across multiple settings. Examples may include housing; food; income; health and dental care; transportation; work, school, or other daily activities; and social life;

    b. The types and frequency of meaningful activities in which a client participates, efforts to increase these activities, and progress made towards their increase;

    c. Natural supports available to the individual and family and how those natural supports are involved in the client's life;

d. The individual's perspective on whether recovery is possible and whether his/her own recovery is supported by important persons in his/her life such as family, friends, professional contacts, and others in the community; and

e. The strategies the individual has used in the past to cope with problems and regain independence. Where appropriate, consideration shall be given in the ISP for expanding the use of these strategies as well as developing additional strategies;

16. A description of the individual's self-identified culture; and

17. If the provider believes the client has a clinical need that the individual does not wish to address, this shall be prominently documented and available for ISP revision.

4.1.8 Crisis services for clients receiving an outpatient benefit

A. In all cases, client need must determine response time. Crisis services may be either emergent or urgent. (See definitions in Section V: Crisis Services Level of Care.)

B. All outpatient providers must provide crisis services 24 hours a day, 365 days a year to all clients authorized to the outpatient level of care. These shall include:

1. Phone crisis services. This service is always considered emergent. Requirements for these services include:

a. The telephone number shall be answered within five rings;

b. If the provider has a voice mail system or answering machine, the first information conveyed must be how to access emergency assistance;

c. A crisis response professional must either be immediately available or accessible by a pager;

d. The caller must be connected with a live person without having to call another number or wait for a call back;

e. Individuals requesting or being referred for crisis services must be able to speak within 15 minutes with a trained mental health crisis staff person for an assessment of the crisis;

f. If the telephone number is answered by someone other than the trained mental health crisis staff person, the call shall be directly transferred to the trained person without requiring the caller to call another number or wait for a call back;

g. However, the caller shall have the choice of staying on the line or hanging up and waiting for a call back;

h. If the caller chooses to stay on the line, the answering service shall maintain periodic contact with the caller until the connection to the crisis staff is completed;

i. There shall be immediate access to interpreter services and to persons who are proficient in the use of TDD or alternate languages to serve persons who are deaf or hard of hearing;

j. Telephone screening services occur according to the "Standardized Initial Crisis Screening Protocol (SICSP)," Section V, Crisis Services Level of Care, Attachment A; and

k. The phone assistance offered should provide as needed basic information and referral services to appropriate mental health, substance abuse, social, and health services as well as assistance in identifying community resources and natural supports.

2. Other crisis services to be provided by all agencies

a. Outreach and stabilization services in clients' homes or to other appropriate places in the community.

b. Service coordination and discharge planning with the staff of the hospital diversion or crisis stabilization placements, for clients placed in those beds.

c. Medication consultation.

d. Procedures to coordinate with the regular treatment staff by the next working day, if the crisis service is provided outside regular business hours.

e. Services that are sensitive to cultural issues and are age-appropriate.

f. Access to the client's crisis plan and advance directive, if applicable.

g. If a client has a Wellness Recovery Action Plan (WRAP) and has requested a copy be available to crisis services staff, there shall be access to the client's WRAP.

3. Additional requirements for crisis services provided by all agencies

a. The crisis intervention staff shall be qualified to provide crisis services. The qualifications shall include:

i. Crisis services experience;

ii. A minimum of a bachelor's degree in a related field or an equivalent combination of education and experience;

iii. Mental health professional or supervised by a mental health professional (or a child mental health specialist when appropriate);

iv. Knowledgeable about community resources and utilization of natural supports;

v. Proficient in assisting callers to identify and utilize their natural supports; and

vi. Skilled in assisting people to problem-solve and use their own strengths, resiliencies, and coping skills to reduce distress.

b. The services may be provided either directly or through a contract or agreement with another outpatient provider that will provide them. If the outpatient provider subcontracts all or part of its crisis services, it must ensure that the subcontractor is providing services according to these policies and procedures.

c. All providers must inform clients authorized to an outpatient level of care about the crisis services available to them, including after-hours crisis support and the availability of other alternatives to inpatient hospitalization.

vii. Providers shall educate clients and/or persons who have legal responsibility for the client about when and how to use the designated crisis number. Providers shall provide this same information to families and/or other natural supports as appropriate.

viii. Providers shall supply their clients with a wallet card that includes necessary crisis information. This information shall also be posted at the provider's clinical site(s).

ix. Clients shall be educated about how to access psychiatric inpatient services, should such services be necessary.

C. Additional crisis services, available to all clients but not provided by each outpatient provider agency

1. Crisis and Commitment Services

a. Designated Mental Health Professionals (DMHP) provide evaluations for involuntary detentions.

b. These services are considered urgent or emergent depending on the clinical needs of the client.

2. Inpatient Diversion Beds for adults

    a. Inpatient Diversion Beds are available to adults who can be appropriately diverted from an inpatient psychiatric hospital admission if given this service.

    b. Referrals to these beds are made by a DMHP or by Crisis Clinic staff.

    c. An initial referral is for five working days. Stays beyond this time frame can be approved in extraordinary circumstances by a KCMHP care manager.

    d. These services are considered urgent or emergent depending on the clinical needs of the client.

3. Inpatient diversion beds for children

4. Inpatient Diversion Beds are available to children and youth who are authorized for outpatient level of care and who can be appropriately diverted from an inpatient psychiatric hospital admission if given this service.

    a. Referrals to these beds are made by outpatient services provider crisis staff or mental health care provider by calling the Children's Crisis Outreach Response System (CCORS) program, which manages this resource.

    b. An initial referral is for 72 hours. Stays beyond this time frame must be approved by CCORS staff and KCMHP clinical staff.

    c. These services are considered urgent or emergent depending on the clinical needs of the client.

4.1.9 Crisis plans

A. Crisis plans shall be developed with all clients who fall into one or more of the following categories:

1. Clients authorized to an outpatient level of care and reimbursed at a 3B case rate.

2. Clients authorized for residential level of care.

3. Any client released within the past 12 months from:

    a. A voluntary or involuntary inpatient setting (including WSH and CLIP facilities);

    b. A jail or Department of Corrections (DOC) facility; or

c. A juvenile detention or Juvenile Rehabilitation Administration (JRA).

4. Clients with co-occurring mental illness and substance use disorders.

5. Clients with current suicide or violent ideation, or who have a history of suicide attempts or violence toward others, or have other clinical indicators that a risk of suicide or harm to others exists.

6. Children and youth involved with two or more systems. Regular school attendance is not considered involvement with another system unless there are other special behavioral health problem indicators present in school.

7. Clients who were served by any hospital emergency department due to a behavioral health crisis at least once in the preceding 12 months.

8. Clients who have a mental health advance directive.

9. All other clients identified by clinicians as being at risk or likely to access crisis services in the next two weeks.

B. Clients shall participate in the development of a crisis plan (see Attachment M: Crisis Plan Form). Where appropriate, family members, significant others, mental health specialists, and/or cultural consultants shall also be involved in the crisis plan development.

1. If the client has culture, language or other specific needs relevant to a crisis, the plan shall include this information.

2. All plans shall address service options that are less restrictive than contacting the DMHPs or referring the client to an emergency room.

3. The outpatient provider shall ensure that all clinicians responding to clients in crisis, including the Crisis Clinic and the DMHPs, shall have 24-hour access to these plans.

4. All plans shall be in the standardized format.

5. For those clients who fit the criteria described in 4.1.10.A above, crisis plans shall be developed within 30 days of assessment for outpatient and residential levels of care, and whenever clinically indicated.

6. The crisis plan shall be reviewed and modified with the participation of the client whenever clinically indicated, at the time of the ISP review, and following every crisis episode.

7. For clients in an on-going crisis, crisis plans shall be updated as often as necessary to reflect any changes needed to effectively resolve the situation.

4.1.10 Services for a client in a hospital emergency department

A. Providers shall respond to all hospital emergency departments (ED) for any client authorized to an outpatient level of care; or

B. On a less restrictive order to their agency, even if a benefit has not yet been authorized as follows:

1. Upon the request of hospital ED staff, the provider shall give a telephone response within two hours of the request;

2. Providers shall give all information that might assist ED staff in resolving the emergency without a hospitalization. This information shall include:

a. Any crisis plan, advance directive, and/or WRAP plan: and

b. Information on how the client may obtain crisis outpatient services on the next business day and any needed medication services within one business week.

3. Phone contact with the ED shall include the option for the provider to speak directly with the client to develop a plan for resolving the emergency without hospitalization.

C. If the above activities do not resolve the emergency, the provider will continue efforts as follows:

1. If the client has not been seen within 48 hours by the provider (case manager, therapist, or prescriber) or if the client has been seen within 48 hours but there have since been changes in the client or his/her circumstances, provider staff will go to the ED within two hours of the phone consult to assist with all services necessary for crisis intervention, stabilization, and hospital diversion (such as daily contacts, use of a diversion bed, medication adjustments and/or implementation of the client's WRAP plan).

2. If the client has been seen within 48 hours by the provider (case manager, therapist, or prescriber) and there are no changes in the client or his/her circumstances, provider staff will determine the need for going to the ED (within two hours of the phone consult) as follows:

a. If both the ED and provider staff recommend admission, no outreach is needed and the hospital will proceed with the admission.

b. If neither the ED nor the provider staff recommend admission, a diversion plan will be developed (or one currently in place will be revised). No outreach is needed.

c. If the ED recommends an admission but the provider does not, no outreach is needed. However, the provider will develop and implement any needed diversion plan and will also contact the hospital authorization staff to explain why the admission is not needed.

d. If the provider recommends an admission but the ED does not, provider will go to the ED to attempt to convince the ED to pursue the admission.

D. If at any time, the ED refers the client for an evaluation for a civil commitment, the provider will go to the ED, if not already there.

1. If the provider recommends the commitment, before leaving the ED, the provider staff shall call the DMHPs to offer assistance with declarations and any other activities to support CCS staff.

2. If the provider does not recommend the commitment, the provider staff need not complete a declaration for the detention.

E. Whenever outreach to the ED is given, the provider shall document the assessment, recommendations, and all other activities. If the hospital does not allow the provider to enter documentation on the hospital's forms, the written documentation shall be given to the ED on provider letterhead.

4.1.11 Services for a client prior to and following a hospitalization

A. For clients authorized to the outpatient level of care, providers are responsible for:

1. Providing timely services, including but not limited to medication services, for those clients potentially in need of a hospitalization, if it appears such services are an appropriate alternative;

2. Identifying and referring persons in need of hospitalization;

3. Coordinating with the hospital as follows:

a. Active involvement of provider staff is expected to take place during a hospital admission process.

i. Provider staff may be asked to personally evaluate the client prior to a potential admission. At a minimum, current clinical information should be provided, such as the current crisis plan, the ISP, and any current mental health advance directive;

ii. When the assigned provider agency staff person does not respond to a request for information within an hour, the mental health professional evaluating the client for admission may contact the supervisor or agency clinical director to obtain the needed assistance;

b. If not done during the admission process, the provider shall make contact with the inpatient team within 24 hours of notification of admission (including weekends) to provide any needed clinical information;

c. If the client has been admitted or transferred to Western State Hospital, in addition to providing the above information to the hospital, the same information shall be provided to the adult inpatient and residential liaison;

d. If clinically indicated, the provider shall have a face-to-face contact with the client within three working days;

e. The provider shall contact the inpatient team within three working days to discuss treatment planning;

f. The provider shall notify the client's outpatient psychiatrist or psychiatric ARNP, if any, so that person may contact the inpatient team to discuss treatment planning;

g. The provider shall have ongoing face-to-face or telephone contact with the client and inpatient team at least once per month while the client is hospitalized; and

h. The provider [and, when appropriate, the child and family (C&F) treatment team] shall assist in discharge planning, including helping the inpatient team determine the appropriate discharge date and updating the ISP and crisis plan. When appropriate, the provider (and/or liaisons) shall assist in the development of a less restrictive court order in order to enable the client to return to the community.

4. Providing timely care on discharge which includes, at a minimum, a face-to-face direct service within seven calendar days following discharge.

5. For clients on psychiatric medications, scheduling prior to the client's discharge a medication management appointment to occur within the time frame negotiated with the hospital.

6. For clients who have a C&F team, the provider in partnership with the family shall facilitate the shared information between the inpatient staff and the C&F team, including information related to continued stay and discharge plans.

7. For clients covered by Medicaid who are denied an authorization request for admission made by provider (not hospital) staff, delivering to the client the Notice of Action that will be faxed to the provider by KCMHP.

B. For referred persons who are not yet authorized to the outpatient level of care but who are eligible for KCMHP services and are not to be waitlisted, KCMHP providers are responsible for:

1. Providing timely assessment, enrollment, and care on discharge which includes, at a minimum, providing a face-to-face direct service within five working days following discharge, and, for clients on psychiatric medications, scheduling prior to the client's discharge a medication management appointment to occur within the time frame negotiated with the hospital;

2. In addition to the above, for clients referred from Western State Hospital;

a. At the request of the adult inpatient and residential liaison, enrolling the referred client prior to discharge and actively participating in discharge planning; or

b. For those clients whose discharge is too imminent to allow time for on-site enrollment, providing outreach and engagement services to ensure that the client receives timely follow-up care even if the initial scheduled appointments are not kept.

C. Hospitals who need additional assistance from a provider may contact that provider's clinical director or a supervisor at the agency phone number or the KCMHP Client Services staff at 1-800-790-8049.

4.1.12 Services for a client on a "less restrictive" court order

A. Providers may not refuse to serve a client covered by Medicaid on a "less restrictive" court order.

B. Services shall be provided according to the requirements in WAC 388-877A- 0195 or its successor.

4.1.13 Services for a client in jail

A. Providers shall respond to the King County jail within one business day following notification of an authorized outpatient client's incarceration by sending the completed Attachment N: Jail Form to the jail health psychiatric staff.

B. Providers shall assist King County jail staff in release planning, including updating the outpatient ISP and crisis plan.

C. Providers shall provide timely care upon release of client which includes, at a minimum, a face-to-face direct service within seven calendar days following jail release.

4.1.14 Medication Evaluation Services

A. Each provider agency shall ensure 24-hours-per-day access to a psychiatrist or ARNP for consultation to the client's assigned clinician or on-call provider staff.

B. All clients authorized for an outpatient benefit shall have access to a psychiatrist or psychiatric ARNP for a face-to-face evaluation within 24 hours of an urgent clinical need.

4.1.15 Coordination of care with primary care providers and chemical dependency treatment providers

A. MH provider agencies shall ensure that each client's primary care provider and chemical dependency treatment provider (if any) are informed of the name of the MH provider agency and how best to contact the client's mental health care provider and psychiatrist or psychiatric ARNP. Specific staff names need not be mentioned.

B. Should the client change primary care or chemical dependency treatment providers, the new providers shall be contacted by the MH provider agency with the contact information as above.

C. Providers need not provide the above information when:

1. The client requests the information not be sent and the provider MH agency concurs with this request or

2. The fact that the agency is providing services and the procedures for contacting the agency are implicit in shared documentation, such as entries by the agency in a nursing home record, shared medical records within an organization that provides both primary care and mental health care, or shared databases regularly used by clinicians, such as the Mental Health Integrated Tracking System (MHITS).

D. For persons without a primary care provider, the mental health provider agency shall document efforts to assist the person in establishing care with one.

4.1.16 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

A. The federal and state requirements of EPSDT for the Medicaid children's population shall be met through the provision of outpatient services.

B. Providers shall ensure face-to-face intake evaluations are completed for all authorized children new to KCMHP outpatient services.

1. Each EPSDT child referred by a health provider shall be contacted to confirm whether services are being requested by the individual or the person authorized to consent to treatment for that individual.

a. The provider shall maintain documentation of its efforts to confirm whether the individual or person authorized to consent to treatment for the individual requests, declines, or does not respond to efforts within 10 working days to confirm whether these services are being requested.

b. If services are requested, an appointment for a mental health intake evaluation must be offered no later than 10 working days from the confirmed request for services by the family or youth.

2. If circumstances occur that prevent the completion of the mental health intake evaluation within this time period, a written description shall be placed in the clinical record documenting the problem(s) encountered, the remedial action(s) to be taken, and a specific timeline to ensure completion of the assessment.

C. For children covered by Medicaid, providers are required to respond to referrals from primary medical care providers. This shall include at least:

1. A written notice replying to the Physician, ARNP, Physician Assistant, trained public health nurse, or RN who made the EPSDT referral. This notice shall include at least the date of the intake and diagnosis; and

2. If the child or family does not identify a medical care provider, the provider shall inform the family of the EPSDT rights contained in the State DSHS Mental Health Benefits booklet to the child or family and identify the following contact information to assist with the selection of a medical provider: Toll free number 1-800-562-3022 or Web site: http://hrsa.dshs.wa.gov/applehealth/.

4.1.17 Vocational Services

A. Providers shall either provide employment services or refer clients for employment services, and/or support clients in maintaining employment.

B. Provide the client with information about how employment will affect his/her income and benefits.

C. Refer the client to the outpatient provider’s own employment program or to one of the Specialty Employment Program (SEP) providers for a vocational assessment, if the client expresses an interest in employment.

D. Coordinate outpatient case rate services with vocational services provided by the provider’s employment program or the SEP.

E. Providers shall document coordination of outpatient services with employment services, including progress towards goals for all clients referred or engaged in an employment program.

4.2 Documentation requirements for outpatient encounters

4.2.1 All clinical services must be recorded in the clinical record with the:

A. Date of service;

B. Service description consistent with procedure code (i.e., CPT or HCPCS) and modifier (if applicable) submitted to King County IS;

C. Service location;

D. Service duration and/or unit;

E. Signature of the clinician providing the service, verifiable against a printed name (name or signature may be generated by the electronic medical record); and

F. Clinician's credentials.

4.2.2 Documentation will occur for each unit of service provided.

4.2.3 The entry must provide enough information to justify the service code.

4.2.4 The entry must be legible to someone other than the writer.

4.2.5 Progress notes will reference the client's current clinical status and response to the ISP.

4.2.6 Documentation of crisis services

A. Documentation must include the date and time each request for a crisis response was received, the date and time of each response was provided, and an indication of whether or not the response was face-to-face.

B. Documentation must demonstrate that emergent crisis services are provided within two hours of the request for such services.

C. Documentation must demonstrate that urgent crisis services are provided within 24 hours of the request for such services.

4.3 Management of Service Utilization

4.3.1 Providers shall have a comprehensive utilization management process that identifies patterns of service utilization by all clients, and includes strategies to ensure that the right services are provided at the right time in the right place (e.g., type, duration, intensity, and frequency).

4.3.2 Providers shall review the agency-specific outpatient service utilization reports provided by KCMHP to identify service utilization patterns for 3A and 3B outpatient benefits. Providers shall determine if the services offered or next benefit level should be changed to reflect the increased or decreased needs of the individual client.

4.3.3 Providers shall develop and implement protocols for the utilization management of their clients who are frequently served by other costly systems, such as residential or inpatient psychiatric care.

KCMHP shall track these clients and work with providers to decrease subsequent use. Efforts to decrease subsequent need for these services. This may include joint provider and KCMHP care conferences. Such care conferences must include the client and informal and/or formal supports as appropriate. If the participation of the client is believed to be clinically contraindicated, the justification for this must be documented.

4.3.4 KCMHP will produce a regular High Utilization Report of persons who have had three or more KCMHP-authorized psychiatric hospitalizations in the preceding 12 months.

A. The report will include the outpatient provider with which the client is authorized to receive outpatient services.

B. Persons who are not authorized with an outpatient provider will be identified on the report separately.

C. Provider-specific client lists will be shared quarterly with each provider's clinical director.

D. Providers will participate in KCMHP-approved quality improvement initiatives.

4.3.5 If the person listed on the High Utilization Report is not authorized for KCMHP outpatient services, KCMHP staff will notify the adult inpatient and residential liaisons.

A. The liaisons will determine whether the person meets KCMHP eligibility criteria and is willing to receive outpatient treatment. If these conditions are met, the liaison will contact KCMHP staff.

B. KCMHP will then refer the person to the provider nearest to the person's home address or to another provider of the person's choice.

5.0 INFORMATION SYSTEMS BUSINESS RULES:

5.1 The provider shall ensure that all data stored on the MHCADSD IS describing the client and any services received under the case rate are complete and accurate.

5.2 Eligibility

5.2.1 Medicaid status requirements

A. KCMHP will use Medicaid dollars to pay for services for only those King County residents who are identified by the DSHS ProviderOne system. MHCADSD IS will identify eligible clients by processing ProviderOne eligibility data at least four times per month and storing eligibility information in the MHCADSD IS.

B. KCMHP will confirm eligibility by doing the following:

1. Every night the MHCADSD IS will verify Medicaid eligibility of persons currently authorized for the outpatient level of care based on the eligibility information stored in the MHCADSD IS and identify clients who are not Medicaid-eligible;

2. A provider will submit a help ticket if they believe the Medicaid eligibility for a client is not reflected accurately in the MHCADSD IS.

C. Actions after a determination of ineligibility are as follows:

1. Medicaid eligibility is assessed for every month the benefit is active. The benefit will be put on non-payment status for each month without Medicaid eligibility;

2. When a benefit is on non-payment status, the provider may:

a. Terminate the benefit and either:

i. Request a non-Medicaid benefit through the non-Medicaid waitlist process, if an electronic request is submitted, if resources are available in the agency's quarterly allocation, and if the person qualifies for a non-Medicaid benefit; or

ii. End all services. If the person will not be continuing services, a Notice of Determination will be sent by KCMHP informing the person of the reason for the termination, e.g., it has been determined the person no longer has Medicaid coverage and KCMHP has insufficient non-Medicaid funding to pay for additional services (see Section III: Clients Rights);

b. Continue the person on non-payment status until the benefit expires;

5.2.2 Coverage types are as follows:

Coverage Type		Eligibility for Benefits if Criteria are Met
F19	King County resident with RSN eligible Medicaid coverage	Eligible for KCMHP outpatient benefits
MID	MIDD funded non-Medicaid benefit	Eligible for KCMHP outpatient benefits, when funding is available
OCM	Out-of-County—Medicaid	Not eligible for KCMHP benefits
OCU	Out-of-County—Non-Medicaid	Not eligible for KCMHP benefits
PHP	King County resident without RSN eligible Medicaid coverage: • "Non-Medicaid", and • <200% poverty adult or older adult; or • <300% poverty child	Eligible for KCMHP outpatient benefits, when funding is available
PRI	First priority non-Medicaid benefit	Eligible for KCMHP outpatient benefits, when funding is available
RSN	King County resident without RSN eligible Medicaid coverage: • "Non-Medicaid" and • >/=200% poverty adult or older adult; or • >/=300% poverty child	Eligible for some carve-outs only
SUS	Indicates that a benefit that started out as Medicaid funded is in non-payment status (suspended).	

5.3 Authorization

5.3.1 Data status and timelines

A. Authorization to the outpatient level of care occurs entirely electronically in most cases. Requests must be submitted in accordance with the "Authorization Request" transaction (see Section XII: Information Management, Attachment B).

B. When an authorization request electronically submitted by a provider is successfully processed, the authorization is assigned an authorization number and data status. Data status is updated as needed when additional data are added.

C. Data status is coded as follows:

ID	Insufficient Data for Payment
PY	Payment Data Set Complete
VL	Validation of Clinical Data Set Complete
OC	Outcome Data Set Complete

D. ID status means that the data are incomplete. No benefit payment occurs. Additional data need to be submitted by the provider.

E. PY status means that adequate data for authorization have been submitted and the authorization is qualified to be paid. Payment will begin, according to the case rate calculation, except when:

   1. Manual review by the clinical team is required, as with 3B case rate requests; or

   2. The person does not meet financial criteria for outpatient benefits.

F. VL status means that additional required clinical data have been received, such as baseline data for outcomes.

G. If an authorization does not meet VL status by the end of the second calendar month ("second month cutoff date"), the authorization is put on non-payment status until the provider either submits the missing data or terminates the benefit.

H. OC status means that outcome data have been received.

I. If an authorization does not meet OC status by the end of the third calendar month ("third month cutoff date"), payment is stopped. For each month past the third month cutoff date, a stop payment status will be set for that month until outcome data are complete.

J. All authorizations are tested for submitted data and data statuses are updated each day.

K. The provider is notified each time the data status changes.

L. Data posting timelines

   1. MHCADSD IS is responsible for ensuring that data are posted to the master event tables no later than 7 p.m. on the day following the day of the provider data submission.

   2. The dates of posting submitted data to the master tables are the dates used to determine data timeline compliance and data status.

5.3.2 Request for service

A. For persons covered by Medicaid who are not currently receiving an outpatient or residential benefit, the 837P transaction with the "request for services" code has to be submitted after the Authorization Request transaction has been successfully processed and the authorization number has been assigned. See Section XII: Information Management, Attachment D.

B. For persons not covered by Medicaid who are not currently receiving an outpatient or residential benefit, the following should occur:

1. If non-Medicaid funds are immediately available for the person's care, the authorization request and 837P transaction with the "request for services" code are submitted in the same manner as noted above for persons covered by Medicaid (see Section XII: Information Management, Attachment D); and

2. If non-Medicaid funds are not immediately available, the authorization request without the "request for services" transaction should be submitted and the client will be waitlisted. If/when funds become available, a provider is to offer services to the person on the waiting list. The reportable 'request for service' date is the date when the provider contacts the individual from its non-Medicaid waiting list and the client indicates that he/she still wants service.

C. The following data submission and timeline requirements apply, depending on the client's status:

Person Covered by Medicaid			
Shows for intake	Meets medical necessity criteria	Send: • Authorization request transaction, and • 837P transaction With CPT codes: • 'Request for Services' and • 'Intake'	Within 9 calendar days of the date the intake was initiated
Shows for intake	Meets medical necessity criteria but provider declines to request an authorization	Contact KCMHP clinical team • See Section III: Client Rights, Attachment I for form	Within 3 working days of the determination of medical necessity
Shows for intake	Does not meet medical necessity criteria	Send: • Authorization request transaction (program '112'), and • Medicaid Coverage transaction • 837P transaction With CPT codes: • 'Request for Services' and • 'Intake' (*triggers notification letter and payment for performing the intake)	Within 9 calendar days of the date the intake was initiated.
Never shows for intake	NA	Send: • Authorization request transaction (program '00'), and • 837P transaction With CPT code: • 'Request for Services'	Within **30** calendar days of the last scheduled intake appointment
Never offered an intake	NA	Contact KCMHP clinical team • See Section III: Client Rights, Attachment I for form	Within 3 working days of the failure to offer

Person Not Covered by Medicaid **RSN resources are available to pay for all or part of care**			
Shows for intake	Meets medical necessity	Send: • Authorization request transaction, and • 837P transaction With CPT codes: • 'Request for Services', and • 'Intake'	Within 9 calendar days of the date the intake was initiated
Shows for intake	Meets medical necessity criteria but provider declines to request an authorization	Contact KCMHP clinical team • See Section III: Client Rights, Attachment I for form	Within 3 working days of the determination of medical necessity
Shows for intake	Doesn't meet medical necessity	Send: • Authorization request transaction (program 112), and • Medicaid Coverage transaction • 837P transaction With CPT codes: • 'Request for Services', and • 'Intake' (* triggers notification letter)	Within 9 calendar days of the date the intake was initiated.
Never shows for intake	NA	NA	NA
Never offered an intake (this applies to First Priority persons not covered by Medicaid always and to Second Priority persons not covered by Medicaid only when resources are available)	NA	Contact KCMHP clinical team • See Section III: Client Rights, Attachment I for form	Within 3 working days of the failure to offer

5.4 Authorization process

5.4.1 All authorization requests are processed within 24 hours of MHCADSD IS receipt of the request.

5.4.2 When a provider has submitted adequate data for a PY status, the data are tested to ensure that the client:

A. Has a covered diagnosis;

B. Has a qualifying GAF/CGAS score; and

C. Meets coverage and residency requirements.

5.4.3 For 2X and 3A case rates, if these tests indicate the client is eligible and meets medical necessity criteria, the authorization status code becomes AA (see Section 5.5.1 AA below), a case rate is determined (see Section 5.6 Case Rate Calculation below), and payment begins, retroactive to the start date of the outpatient benefit. For the 3B case rate, the status code becomes PN. PN means an outpatient benefit has been authorized. However, payment begins, retroactive to the start date of the benefit, only after the manual review is completed and the request is approved by MHCADSD clinical team.

5.4.4 Eligibility, medical necessity, and the case rate are tested and if necessary recalculated by MHCADSD IS processes on daily basis.

5.4.5 When there is adequate information to document eligibility for outpatient services, but insufficient information is provided to approve a level 3A or 3B case rate, a level 2 case rate will be approved.

5.4.6 For non-routine situations, KCMHP clinical team may also create a retroactive authorization, posting an authorization record without an existing authorization request.

5.5 Authorization Status Codes

5.5.1 At any one time, an authorization request will have one of the following status codes:

UA	Unauthorized • Authorization request meets technical requirements and authorization number has been assigned. • However, there is inadequate information to complete the authorization.
AA	Approved • Authorization meets coverage requirements and minimum Medical Necessity for the outpatient level of care. • Authorization is approved for an outpatient benefit and payment begins at the requested case rate. • However, the final case rate is not determined until the second month cutoff date. • See Section 5.8 below on Validation of Clinical Criteria.
CX	Canceled • Authorization is canceled. • Any payments made are recouped.
PN	Pending Manual Review • Authorization meets coverage requirements and minimum Medical Necessity for the outpatient level of care. • Authorization is approved for an outpatient benefit. • However, final approval for the 3B case rate requires Manual Review by KCMHP clinical team. • When approved, payment is retroactive.

TM	Terminated • Authorization has been terminated. • Only payments made after the termination date are recouped.
WL	Waitlisted • Authorization Waitlisted (for non-Medicaid only)

5.5.2 Providers receive daily reports whenever a change in the authorization status code for an authorization has occurred.

5.5.3 When an authorization request cannot be processed, the provider will be notified via daily error reports.

5.6 Case Rate Calculation

5.6.1 The case rate is calculated based on:

A. Age of the client;

B. The client's need for interpreter services;

C. The eligibility of the client for the cultural differential;

D. The type of agency that will be delivering the services; and

E. The client's Medicaid status.

(See Section IV: Financial Management, Attachment A, Case Rates.)

5.6.2 Each case rate is calculated daily based on the data in the MHCADSD IS master tables. Changes in the data may lead to a recalculation of the case rate and a reconciliation of the monthly payments.

5.7 Cultural differential

5.7.1 Case rates are increased for persons who are:

A. Ethnic minorities;

B. Sexual minorities;

C. Homebound; or

D. Deaf or hard-of-hearing.

5.7.2 For clients who are identified as being of an ethnic and/or sexual minority, the cultural differential is applied only following a mental health specialist (MHS) evaluation or consultation.

A. For a client's first benefit:

1. If the MHS evaluation or consultation occurs within the first three months of the benefit, the differential is applied retroactively to the start date for the benefit;

2. If the MHS evaluation or consultation occurs later in the benefit, the differential is applied prospectively only beginning with the calendar month following this service;

B. For renewing benefits or a benefit initiated because of a change in funding, the cultural differential case rate will be paid for the new benefit if the client has had a MHS evaluation or consultation reported to MHCADSD IS by the agency requesting the benefit within the last calendar year.

5.7.3 For clients who are homebound and hearing-impaired, the cultural differential is applied from the start date for the benefit.

5.8 Validation of the Clinical Criteria for a Case Rate

5.8.1 This validation ensures that the case rate requested is supported by the submitted clinical data.

5.8.2 All authorized outpatient benefits have a Clinical Criteria (CC) validation status.

5.8.3 CC validation status 0 means that authorization meets clinical criteria for requested case rate.

5.8.4 All other codes indicate the reason why the clinical criteria for requested case rate were not met.

5.8.5 When the clinical criteria for a requested case rate are not met, the Case Rate High indicator displays the highest case rate that can be approved for the clinical criteria submitted.

5.8.6 Combination of CC validation status not equal to 0 and NULL value for Case Rate High indicator indicates that the submitted clinical data do not meet minimum Medical Necessity requirements for an outpatient benefit and the benefit is subject for cancellation.

5.8.7 On the last day of the second calendar month ("second month cutoff date"), the following will occur:

A. Benefits with CC validation status not equal to 0 and NULL values for Case Rate High indicator are cancelled;

B. Benefits with CC validation status not equal to 0 and not NULL value for Case Rate High indicator are automatically converted to the case rate indicated by the Case Rate High indicator (this rule does not apply to '3B1' requests that are still subject to Manual Review); and

C. When a case rate is converted to a different case rate level, this leads to a recalculation of the case rate and a reconciliation of the payments.

5.8.8 Changes in the clinical data may be made until the clinical data cutoff date ("third month cutoff date").

5.8.9 Every change in the CC calculation is reported to providers.

5.9 Non-Medicaid Authorization

5.9.1 Every submitted non-Medicaid benefit request is first tested against the non-Medicaid eligibility and minimum clinical criteria.

A. All outpatient authorizations are initially assigned an authorization status of Unauthorized (UA).

B. The authorization status changes to Waitlist (WL) when:

1. Data status of PY is met;

2. Client meets requirements for MHP coverage (i.e., client is low-income as defined in the table above);

3. Minimal clinical criteria are met, and

4. Client has been assigned a qualifying condition status that identifies which special eligibility criterion is met.

5.9.2 Clients with WL status will have one of the following occur:

A. Clients who are Non-Medicaid Priorities immediately go to Authorization Approved (AA) status; and

B. For all others, the authorization will be tested against the provider's non-Medicaid allocation. When there are sufficient dollars left in the provider's allocation to cover the projected cost of the outpatient authorization of the requested case rate, the authorization will be taken off the waitlist, given a status of AA, and the authorization will follow standard authorization processes.

5.9.3 Non-Medicaid Waitlist Management

A. Non-Medicaid benefit requests that meet the non-Medicaid eligibility and clinical criteria will be put on the waitlist in the order in which they were received.

B. By the beginning of each quarter, each provider will receive a non-Medicaid allocation, based on available non-Medicaid funds.

C. Benefits will be authorized in the order of waitlist postdate.

1. The start date of an authorized WL status outpatient authorization is the authorization's assessment date, except when the client is requesting a continuing benefit, in which case the start date follows the completion of the current benefit.

2. When there are insufficient dollars left in the provider's quarterly allocation, no more non-Medicaid outpatient authorizations will be authorized from the waitlist to the provider. Person remains in WL status. The authorization will stay with 'WL' status until the first day of the fourth month from authorization's assessment date. The authorization gets cancelled on that day.

D. If a client receiving a non-Medicaid benefit receives Medicaid coverage, the benefit will convert to a Medicaid benefit with no action required by the provider. The non-Medicaid dollars freed up are not returned to the provider's allocation, unless the authorization is canceled within the same quarter.

5.9.4 Cancellation of Waitlist Outpatient Authorization Requests

A. Where a waitlisted outpatient authorization does not meet data or CC status at the second month cutoff date, the authorization will be cancelled.

B. On a daily basis, qualifying condition status code will be retested for all authorizations on the waitlist, based on information in the MHCADSD IS. Authorizations that no longer meet the non-Medicaid qualifying condition to be on the waitlist will be removed.

5.9.5 Authorization Response Record

A. Providers shall receive notification of every response taken on each authorization request submitted. [See the Authorization Response Transaction in the "Provider Technical Reference" (available online) for format.]

B. An authorization response record is created when changes made to the submitted clinical, demographic, or authorization data affect case rate, CC status code, authorization duration, or authorization status.

5.9.6 Case Rate Change Request for an existing outpatient authorization

A. Case rate changes may be requested only:

1. Prior to the second month cutoff date; or

2. After this date, when a catastrophic change in the client's condition has occurred.

B. A request for a case rate change must refer to a valid authorization that has not been canceled, terminated, or placed on non-payment status.

C. For changes requested prior to the second month cutoff date:

1. The authorization number and the start date are unchanged;

2. The case rate change requested by the provider is assigned in the MHCADSD IS without regard to case rate criteria; validation will occur later when the authorization is retested for data timelines and case rate criteria; and

3. The case rate re-determination is retroactive to the start date of the authorization and an adjustment will be made to any payments.

D. For requests to change the case rate due to a catastrophic and permanent change in the client:

1. The assessment date of the new request must be after the second month cutoff date and on or before the expiration date of the existing authorization;

2. A pending outpatient authorization is created with a start date equal to the new assessment date and new benefit requested;

3. The pending authorization requires a manual review; and

4. Upon approval by KCMHP, the existing outpatient authorization is terminated as of the day before the new assessment date.

5.10 Continuing Stay

For provider request to renew an existing authorization benefit:

5.10.1 The assessment date of the request must be within the last 30 days of the current authorization;

5.10.2 The posting date of the continuation request must be on or before the "second month cutoff date" of the next authorization request;

5.10.3 For Medicaid clients, the start date of the new authorization will be set to the day following the expiration date of the current authorization. The start of an authorization for outpatient services for a person on the waitlist is the day the request is authorized and removed from the waitlist;

5.10.4 The provider may request a new case rate that is different from the case rate of the existing authorization;

5.10.5 For Medicaid clients, a request for a next benefit must refer to a valid authorization that has not been canceled or terminated. If the client has lost Medicaid coverage and the request is for a benefit funded by non-Medicaid dollars, the request may refer to an authorization that has been terminated; and

5.10.6 All other aspects of requesting a continued authorization are the same as requesting an initial authorization.

5.11 Terminations

5.11.1 Provider Request for Termination

A. The posting date must be no more than 60 days after the expiration date of the existing authorization.

B. The existing authorization must not already be canceled or terminated.

C. The authorization does not have a pending manual review.

5.11.2 Termination of a benefit due to prolonged hospital stay:

A. If the hospitalization has occurred at Western State Hospital or non-King County CLIP facilities and has lasted over 90 days, the provider must submit an updated "residential arrangement transaction," which includes the new residential code, the new zip code, and the code for the new county of residence (see Section VII: Information Management, Attachment B); and

B. If the hospitalization is at Western State Hospital, the provider has 30 days after discharge to submit an updated "residential arrangement transaction." If this transaction is not received by day 90 of the benefit, the authorization will be terminated effective the 60th day of the benefit.

5.11.3 Termination of a benefit due to prolonged detention/incarceration:

A. If an incarceration has lasted over 60 days, the provider must submit an updated "residential arrangement transaction" and an updated "Medicaid coverage transaction"; and

B. The provider has 30 days after release to submit an updated "residential arrangement transaction."

5.11.4 Authorizations that are terminated are paid through the termination date.

5.12 Cancellations

5.12.1 Provider Request for Cancellation

A. Providers may submit Notice of Exit transaction (see Section XII: Information Management, Attachment B) to request cancellation of an existing authorization.

B. The posting date must be on or before the authorization change cutoff date.

C. The existing authorization request must not already have a cancellation status.

D. LTR authorizations can only be canceled by MHCADSD.

5.12.2 Authorizations that are cancelled are subject to recoupment.

6.0 FINANCIAL BUSINESS RULES:

6.1 Case rates

6.1.1 Providers are paid for the delivery of outpatient services according to a case rate model.

6.1.2 Providers are prepaid monthly.

A. For services to clients with ongoing benefits, providers receive the monthly case rate for that client at the start of the month for services to be provided during that month.

B. For services to new clients or to clients ending services, adjustments to payment may be applied retroactively.

C. Additional adjustments may occur as needed.

6.1.3 Case rate determination when a client has other sources of funding

A. In general, KCMHP expects that if a client is also receiving intensive behavioral health care services reimbursed through another funding source (for example, the state Division of Child and Family Services), no greater than a 3A case rate will be requested.

B. If, in these circumstances, a client meets the case rate criteria for a 3B case rate and the 3B case rate is requested, the pre-approval process will be the same as for other 3B requests, with the addition that the ISP must clearly state which system is funding the specific parts of the plan.

6.1.4 Providers sharing services

A. A client is limited to one outpatient authorization at a time. The provider holding the authorization will receive the case rate for the client and is responsible for coordinating all care.

1. A client may receive services from certain carve-out programs while receiving KCMHP outpatient services.

2. A client may not have a HOST or COD case management status and an outpatient or residential authorization except as specified in Section IX: Additional Services.

B. Providers may share care for a client based on arrangements made between them. However, only the single authorized provider will receive the case rate. The provider holding the KCMHP outpatient authorization is responsible for client care and associated administrative responsibilities and shall be deemed the data provider responsible for maintaining client data accuracy.

6.1.5 Payment of subcontractors

If a provider chooses to have a credentialed subcontractor provide services to an authorized client, it is the responsibility of the provider and subcontractor to negotiate payment for services.

6.1.6 Allocation of resources for outpatient services for clients not covered by Medicaid

A. The available budget for access for clients not covered by Medicaid will be divided into two portions: one for access for clients not covered by Medicaid who meet the general non-Medicaid eligibility criteria, and one for the clients not covered by Medicaid who will be admitted as non-Medicaid priorities as described above.

B. The budget for general access for clients not covered by Medicaid will be divided into quarterly amounts in order to allow KCMHP to adjust the budget as necessary to reflect actual expenditures and any budget changes that result from legislative actions.

C. Each provider will receive a specific allocation of the quarterly non-Medicaid general access budget. KCMHP will publish the allocation for each quarter by the end of the second week of the month preceding the start of the next quarter. Each provider's specific allocation may vary by quarter depending on expenditures and continued availability of funds to serve the non-Medicaid population.

D. Providers are expected to manage their wait list to the allocated dollar amount. If a provider uses its allocation before the end of the quarter the provider may place clients not covered by Medicaid on the waitlist for admission in the subsequent quarter. Providers must cancel the benefit if a waitlisted person is no longer seeking services.

E. Assessment and wait listing do not constitute an authorization.

F. The start of an authorization for outpatient services for a person on the waitlist is the day the request is authorized and removed from the waitlist.

7.0 LIST OF ATTACHMENTS:

7.1 Attachment A: Access to Care Standards

7.2 Attachment B: Additional Criteria for Diagnosis B for Children Age 6 and Older

7.3 Attachment C: Additional Criteria for Diagnosis B for Adults and Older Adults

7.4 Attachment D-1: Non-Medicaid Priorities and Exceptions Request Form (for agencies with a quarterly allocation)

7.5 Attachment D-2: Non-Medicaid Priorities and Exceptions Request Form (for agencies without a quarterly allocation)

7.6 Attachment E: Non-Medicaid Access Diagnosis Codes

7.7 Attachment F: Clinical Case Rate Criteria

7.8 Attachment G: Clinical Case Rate Criteria Decision Tree

7.9 Attachment H: Assessment Scales

7.10 Attachment I: Checklist for Case Review

7.11 Attachment J: ETP Request Form

7.12 Attachment K: State Plan Modalities

7.13 Attachment L: Co-Occurring Disorder Screening and Assessment

7.14 Attachment M: Crisis Plan Form

7.15 Attachment N: Jail Form

7.16 Attachment O: Conditions and Circumstances Impacting Behavior

7.17 Attachment P: Determining King County RSN Eligibility for People who Live in Zip Codes that Overlap Counties

8.0 REFERENCES:

Washington State Law, Regulations, and Policy including any successor, amended, or replacement laws**,** regulations**,** or policies

- Chapters 388-865, 388-877, and 388-877A WAC – Department of Social and Health Services – Mental Health – Community Mental Health and Involuntary Treatment Programs
- Chapter 71.24 RCW – Mental Illness – Community Mental Health Services Act
- Federal 1915(b) Waiver Renewal
- 1995 Legislative Budget Proviso concerning Medicaid Personal Care

Other

- The Department of Social and Health Services (DSHS) State Mental Health Contract and any subsequent amendments.
- The Department of Social and Health Services (DSHS) PIHP Contract and any subsequent amendments.
- Agreement between the KCRSN, Region 4 Home and Community Services, and the King County Area Agency on the Aging
- Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)
- International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), Sixth Edition
- Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood Revised (DC0-3-R)
- The ASQ User's Guide for the Ages & Stages Questionnaires: A Parent-Completed, Child Monitoring System, Second Edition (Paul H. Brooks Publishing Co. www.brookespublishing.com for ordering information)
- The ASQ: SE User's Guide for the Ages & Stages Questionnaires: Social-Emotional: A Parent-Completed, Child-Monitoring System for Social-Emotional Behaviors (Paul H. Brooks Publishing Co. www.brookespublishing.com for ordering information)

Access to Care Standards – 1/1/06
Eligibility Requirements for Authorization of Services for Medicaid Adults and Medicaid Older Adults

Please note: The following standards reflect the authorization criteria that can be applied. <u>The standards should not be applied as continuing stay criteria</u>.

An individual must meet all of the following before being considered for a level of care assignment:
* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Adult and Older Adult Disorders.
* The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
* The intervention is deemed to be reasonably necessary to improve, stabilize, or prevent deterioration of functioning resulting from the presence of a mental illness.
* The individual is expected to benefit from the intervention.
* The individual's unmet need cannot be more appropriately met by any other formal or informal system or support.

***** = *Descriptive Only***

	Level One – Brief Intervention	**Level Two – Community Support**
Goal and Period of Authorization*	Brief Intervention Treatment/short-term crisis resolution is necessary for the purpose of strengthening ties within the community, identifying and building on innate strengths of the family and/or other natural supports and preventing the need for long-term treatment **OR** long-term low intensity treatment is provided allowing a person who has previously received treatment at a higher level of care to maintain their recovery. The period of authorization may be up to 6 months of care **OR** may be up to 12 months of care when an individual is receiving long term, low intensity treatment.	Longer-term treatment is necessary to achieve or maintain stability **OR** requires high intensity treatment to prevent hospitalization, out of home placement and/or decrease the use of other costly services. The period of authorization may be up to six months of care **OR** may be up to 12 months of care as determined by medical necessity and treatment goal(s).
Functional Impairment **<u>Must be the result of a mental illness.</u>**	* **Must demonstrate moderate functional impairment in at least <u>one</u> life domain requiring assistance in order to meet the identified need AND-** * **<u>Impairment is evidenced by a Global Assessment of Functioning (GAF) Score of 60 or below.</u>** **Domains include:** * Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications * Cultural Factors * Home & Family Life Safety & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill needs	* **Must demonstrate serious functional impairment in at least <u>one</u> life domain requiring assistance in order to meet the identified need AND-** * **<u>Impairment is evidenced by a Global Assessment of Functioning (GAF) Score of 50 or below.</u>** **Domains include:** * Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications * Cultural Factors * Home & Family Life Safety & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill needs

Access to Care Standards – 1/1/06
Eligibility Requirements for Authorization of Services for Medicaid Adults and Medicaid Older Adults

Please note: The following standards reflect the authorization criteria that can be applied. The standards should not be applied as continuing stay criteria.

An individual must meet all of the following before being considered for a level of care assignment:
* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Adult and Older Adult Disorders.
* The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
* The intervention is deemed to be reasonably necessary to improve, stabilize, or prevent deterioration of functioning resulting from the presence of a mental illness.
* The individual is expected to benefit from the intervention.
* The individual's unmet need cannot be more appropriately met by any other formal or informal system or support.

**** = Descriptive Only***

	Level One – Brief Intervention	Level Two – Community Support
Covered Diagnosis	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Special population consultation should be considered. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Adult & Older Adult Disorders)	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Special population consultation should be considered. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Adult & Older Adult Disorders)
Supports & Environment*	May have limited social supports and impaired interpersonal functioning due to mental illness. Individual and natural supports may lack resources or have difficulty accessing entitlements (food, income, coupons, transportation) or available community resources; language and/or cultural factors may pose barriers to accessing services. May be involvement with one or more additional formal systems requiring coordination. Requires treatment to develop supports, address needs and remain in the community.	May have lack of or severely limited natural supports in the community due to mental illness. May be involvement with one or more formal systems requiring coordination in order to achieve goals. Active outreach may be needed to ensure treatment involvement. Situation exceeds the resources of the natural support system.
Minimum Modality Set	Access to the following modalities is based on clinical assessment, medical necessity and individual need. Individuals may be referred for the following treatment: * Brief Intervention Treatment * Medication Management * Psychoeducation * Group Treatment The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.	Access to the following modalities is based on clinical assessment, medical necessity and individual need. In addition to the modalities listed in Level of Care One, individuals may be referred for the following treatment: * Individual Treatment * Medication Monitoring * Peer Support The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need.
Dual Diagnosis	Individuals who have both a covered and a non-covered diagnosis are eligible for service based on the covered diagnosis.	Individuals who have both a covered and a non-covered diagnosis are eligible for service based on the covered diagnosis.

Access to Care Standards – 1/1/06
Eligibility Requirements for Authorization of Services for Medicaid Children & Youth

Please note: The following standards reflect the authorization criteria that can be applied. <u>The standards should not be applied as continuing stay criteria.</u>

An individual must meet all of the following before being considered for a level of care assignment:
* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Childhood Disorders.
* The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
* The intervention is deemed to be reasonably necessary to improve, stabilize, or prevent deterioration of functioning resulting from the presence of a mental illness.
* The individual is expected to benefit from the intervention.
* The individual's unmet need would not be more appropriately met by any other formal or informal system or support.

**** = Descriptive Only***

	Level One - Brief Intervention	**Level Two - Community Support**
Goal & Period of Authorization*	Brief Intervention Treatment/short term crisis resolution is necessary for the purpose of strengthening ties within the community, identifying and building on innate strengths of the family and/or other natural supports and preventing the need for long term treatment **OR** long term low intensity treatment is provided allowing a person who has previously received treatment at a higher level of care to maintain their recovery. The period of authorization may be up to six months of care **OR** may be up to 12 months of care when an individual is receiving long term, low intensity treatment.	Longer-term treatment is necessary to achieve or maintain stability **OR** requires high intensity treatment to prevent hospitalization, out of home placement and/or decrease the use of other costly services. The period of authorization may be up to six months of care **OR** may be up to 12 months of care as determined by medical necessity and treatment goal(s).
Functional Impairment **Must be the result of an emotional disorder or a mental illness.**	* **Must demonstrate moderate functional impairment in at least <u>one</u> life domain requiring assistance in order to meet the identified need AND-** * **<u>Impairment is evidenced by a Children's Global Assessment Scale (CGAS) Score of 60 or below.</u>** (Children under 6 are exempted from CGAS.) **Domains include:** Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications Cultural Factors * Home & Family Life Safety & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill needs	* **Must demonstrate severe and persistent functional impairment in at least <u>one</u> life domain requiring assistance in order to meet identified need AND-** * **<u>Impairment is evidenced by a Children's Global Assessment Scale (CGAS) Score of 50 or below.</u>** (Children under 6 are exempted from CGAS.) **Domains include:** Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications Cultural Factors * Home & Family Life Safety & Stability * Work, school, daycare, pre-school or other daily activities * Ability to use community resources to fulfill need

Access to Care Standards – 1/1/06
Eligibility Requirements for Authorization of Services for Medicaid Children & Youth

Please note: The following standards reflect the authorization criteria that can be applied. <u>The standards should not be applied as continuing stay criteria.</u>

An individual must meet all of the following before being considered for a level of care assignment:

* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Childhood Disorders.
* The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
* The intervention is deemed to be reasonably necessary to improve, stabilize, or prevent deterioration of functioning resulting from the presence of a mental illness.
* The individual is expected to benefit from the intervention.
* The individual's unmet need would not be more appropriately met by any other formal or informal system or support.

*** = *Descriptive Only***

	Level One - Brief Intervention	**Level Two - Community Support**
Covered Diagnosis	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Consultation with a children's mental health specialist is required. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Childhood Disorders)	Assessment is provided by or under the supervision of a mental health professional and determines the presence of a covered mental health diagnosis. Consultation with a children's mental health specialist is required. Diagnosis A = Covered Diagnosis B = Covered + One Additional Criteria (See Covered Childhood Disorders)
Supports & Environment*	Natural support network is experiencing challenges, i.e., multiple stressors in the home; family or caregivers lack resources or have difficulty accessing entitlements (food, income, coupons, transportation) or available community resources; language and/or cultural factors may pose barriers to accessing services. May be involvement with one or more child-serving systems requiring coordination.	Significant stressors are present in home environment, i.e., change in custodial adult; out of home placement; abuse or history of abuse; and situation exceeds the resources of natural support system. May be involvement with one or more child serving system requiring coordination.
EPSDT Plan	Level One Services are defined as short-term mental health services for children/families with less severe need. An ISP should be developed and appropriate referrals made. Children eligible for Level One EPSDT services in the 1992 EPSDT plan are included here.	Children eligible for Level Two EPSDT services in the 1992 EPSDT plan are defined as needing longer term, multi-agency services designed to meet the complex needs of an individual child and family. Level Two is authorized for children with multi-system needs or for children who are high utilizers of services from multiple agencies. EPSDT children authorized for this level will be referred to and may require an individual treatment team in accordance with the EPSDT Plan.

Access to Care Standards – 1/1/06
Eligibility Requirements for Authorization of Services for Medicaid Children & Youth

Please note: The following standards reflect the authorization criteria that can be applied. <u>The standards should not be applied as continuing stay criteria.</u>

An individual must meet all of the following before being considered for a level of care assignment:

* The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Childhood Disorders.
* The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
* The intervention is deemed to be reasonably necessary to improve, stabilize, or prevent deterioration of functioning resulting from the presence of a mental illness.
* The individual is expected to benefit from the intervention.
* The individual's unmet need would not be more appropriately met by any other formal or informal system or support.

*** = *Descriptive Only***

	Level One - Brief Intervention	**Level Two - Community Support**
Minimum Modality Set	**Access to the following modalities is based on clinical assessment, medical necessity, and individual need. Individuals may be referred for the following treatment:** * Brief Intervention Treatment * Medication Management * Psychoeducation * Group Treatment * Family Supports The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity, and individual need.	**Access to the following modalities is based on clinical assessment, medical necessity, and individual need. <u>In addition to the modalities listed in Level of Care One,</u> individuals may be referred for the following treatment:** * Individual Treatment * Medication Monitoring The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity, and individual need.
Dual Diagnosis	Individuals who have both a covered and a non-covered diagnosis may be eligible for service based on the covered diagnosis.	Individuals who have both a covered and a non-covered diagnosis may be eligible for service based on the covered diagnosis.

Washington State Medicaid Program
Minimum Covered Diagnoses for Medicaid Adults and Medicaid Older Adults
1/1/06

Washington State defines acutely mentally ill, chronically mental ill adult, seriously disturbed person, and severely emotionally disturbed child in Chapters 71.24 and 71.05 Revised Code of Washington (RCW). The following diagnoses are considered to further interpret the statute criteria in establishing eligibility under the Washington State Medicaid Program. Additional eligibility requirements must be met to qualify for outpatient mental health services. Minimum eligibility requirements for authorization of services for Medicaid Adults and Older Adults are further defined in the Access to Care Standards.

Please note: *The following covered diagnoses must be considered for eligibility.*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
	ATTENTION-DEFICIT AND DISRUPTIVE BEHAVIOR DISORDERS	
314.01	Attention-Deficit/Hyperactivity Disorder, Combined type	B
314.00	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type	B
314.01	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type	B
314.9	Attention-Deficit/Hyperactivity Disorder DOS	B
	DEMENTIA	
294.10	Dementia of the Alzheimer's Type, With Early Onset Without Behavioral Disturbance	B
294.11	Dementia of the Alzheimer's Type, With Early Onset With Behavioral Disturbance	B
294.10	Dementia of the Alzheimer's Type, With Late Onset Without Behavioral Disturbance	B
294.11	Dementia of the Alzheimer's Type, With Late Onset With Behavioral Disturbance	B
290.40	Vascular Dementia Uncomplicated	B
290.41	Vascular Dementia With Delirium	B
290.42	Vascular Dementia With Delusions	B
290.43	Vascular Dementia With Depressed Mood	B
294.10	Dementia Due to HIV Disease Without Behavioral Disturbance	B
294.11	Dementia Due to HIV Disease With Behavioral Disturbance	B
294.10	Dementia Due to Head Trauma Without Behavioral Disturbance	B
294.11	Dementia Due to Head Trauma With Behavioral Disturbance	B
294.10	Dementia Due to Parkinson's Disease Without Behavioral Disturbance	B
294.11	Dementia Due to Parkinson's Disease With Behavioral Disturbance	B
294.10	Dementia Due to Huntington's Disease Without Behavioral Disturbance	B
294.11	Dementia Due to Huntington's Disease With Behavioral Disturbance	B
294.10	Dementia Due to Pick's Disease Without Behavioral Disturbance	B
294.11	Dementia Due to Pick's Disease With Behavioral Disturbance	B
294.10	Dementia Due to Creutzfeldt-Jakob Disease Without Behavioral Disturbance	B
294.11	Dementia Due to Creutzfeldt-Jakob Disease With Behavioral Disturbance	B
294.10	Dementia Due to… (*Indicate the General Medical Condition not listed above)* Without Behavioral Disturbance	B
294.11	Dementia Due to… (*Indicate the General Medical Condition not listed above)* With Behavioral Disturbance	B
---.--	Substance-Induced Persisting Dementia (*refer to Substance-related Disorders for substance specific codes)*	B
---.--	Dementia Due to Multiple Etiologies	B
294.8	Dementia NOS	B

	OTHER COGNITIVE DISORDERS	
294.9	Cognitive Disorder NOS	B
	SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	
295.30	Schizophrenia Paranoid Type	A
295.10	Schizophrenia Disorganized Type	A
295.20	Schizophrenia Catatonic Type	A
295.90	Schizophrenia Undifferentiated Type	A
295.60	Schizophrenia Residual Type	A
295.40	Schizophreniform Disorder	A
295.70	Schizoaffective Disorder	A
297.1	Delusional Disorder	A
298.8	Brief Psychotic Disorder	A
297.3	Shared Psychotic Disorder	A
293.81	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Delusions	A
293.82	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Hallucinations	A
298.9	Psychotic Disorder NOS	A
	MOOD DISORDERS **DEPRESSIVE DISORDERS**	
296.21	Major Depressive Disorder Single Episode, Mild	A
296.22	Major Depressive Disorder Single Episode, Moderate	A
296.23	Major Depressive Disorder Single Episode, Severe Without Psychotic Features	A
296.24	Major Depressive Disorder Single Episode, Severe With Psychotic Features	A
296.25	Major Depressive Disorder Single Episode, In Partial Remission	A
296.26	Major Depressive Disorder Single Episode, In Full Remission	A
296.20	Major Depressive Disorder Single Episode, Unspecified	A
296.31	Major Depressive Disorder Recurrent, Mild	A
296.32	Major Depressive Disorder Recurrent, Moderate	A
296.33	Major Depressive Disorder Recurrent, Severe Without Psychotic Features	A
296.34	Major Depressive Disorder Recurrent, Severe With Psychotic Features	A
296.35	Major Depressive Disorder Recurrent, In Partial Remission	A
296.36	Major Depressive Disorder Recurrent, In Full Remission	A
296.30	Major Depressive Disorder Recurrent, Unspecified	A
300.4	Dysthymic Disorder	B
311	Depressive Disorder NOS	B

	BIPOLAR DISORDERS	
296.01	Bipolar I Disorder Single Manic Episode, Mild	A
296.02	Bipolar I Disorder Single Manic Episode, Moderate	A
296.03	Bipolar I Disorder Single Manic Episode, Severe Without Psychotic Features	A
296.04	Bipolar I Disorder Single Manic Episode, Severe With Psychotic Features	A
296.05	Bipolar I Disorder Single Manic Episode, In Partial Remission	A
296.06	Bipolar I Disorder Single Manic Episode, In Full Remission	A
296.00	Bipolar I Disorder Single Manic Episode, Unspecified	A
296.40	Bipolar I Disorder Most Recent Episode Hypomanic	A
296.41	Bipolar I Disorder Most Recent Episode Manic, Mild	A
296.42	Bipolar I Disorder Most Recent Episode Manic, Moderate	A
296.43	Bipolar I Disorder Most Recent Episode Manic, Severe Without Psychotic Features	A
296.44	Bipolar I Disorder Most Recent Episode Manic, Severe With Psychotic Features	A
296.45	Bipolar I Disorder Most Recent Episode Manic, In Partial Remission	A
296.46	Bipolar I Disorder Most Recent Episode Manic, In Full Remission	A
296.40	Bipolar I Disorder Most Recent Episode Manic, Unspecified	A
296.61	Bipolar I Disorder Most Recent Episode Mixed, Mild	A
296.62	Bipolar I Disorder Most Recent Episode Mixed, Moderate	A
296.63	Bipolar I Disorder Most Recent Episode Mixed, Severe Without Psychotic Features	A
296.64	Bipolar I Disorder Most Recent Episode Mixed, Severe With Psychotic Features	A
296.65	Bipolar I Disorder Most Recent Episode Mixed, In Partial Remission	A
296.66	Bipolar I Disorder Most Recent Episode Mixed, In Full Remission	A
296.60	Bipolar I Disorder Most Recent Episode Mixed, Unspecified	A
296.51	Bipolar I Disorder Most Recent Episode Depressed, Mild	A
296.52	Bipolar I Disorder Most Recent Episode Depressed, Moderate	A
296.53	Bipolar I Disorder Most Recent Episode Depressed, Severe Without Psychotic Features	A
296.54	Bipolar I Disorder Most Recent Episode Depressed, Severe With Psychotic Features	A
296.55	Bipolar I Disorder Most Recent Episode Depressed, In Partial Remission	A
296.56	Bipolar I Disorder Most Recent Episode Depressed, In Full Remission	A
296.50	Bipolar I Disorder Most Recent Episode Depressed, Unspecified	A
296.7	Bipolar I Disorder Most Recent Episode Unspecified	A
296.89	Bipolar II Disorder	A
301.13	Cyclothymic Disorder	B
296.80	Bipolar Disorder NOS	A
296.90	Mood Disorder NOS	B
	ANXIETY DISORDERS	
300.01	Panic Disorder Without Agoraphobia	B
300.21	Panic Disorder With Agoraphobia	B
300.22	Agoraphobia Without History of Panic Disorder	B
300.29	Specific Phobia	B
300.23	Social Phobia	B
300.3	Obsessive-Compulsive Disorder	B
309.81	Posttraumatic Stress Disorder	A
308.3	Acute Stress Disorder	A
300.02	Generalized Anxiety Disorder	B
300.00	Anxiety Disorder NOS	B

	SOMATOFORM DISORDERS	
300.81	Somatization Disorder	B
300.82	Undifferentiated Somatoform Disorder	B
300.11	Conversion Disorder	B
307.80	Pain Disorder Associated With Psychological Factors	B
307.89	Pain Disorder Associated With Both Psychological Factors and a General Medical Condition	B
300.7	Hypochondriasis	B
300.7	Body Dysmorphic Disorder	B
300.82	Somatoform Disorder NOS	B
	FACTITIOUS DISORDERS	
300.16	Factitious Disorder With Predominantly Psychological Signs and Symptoms	B
300.19	Factitious Disorder With Predominantly Physical Signs and Symptoms	B
300.19	Factitious Disorder With Combined Psychological and Physical Signs and Symptoms	B
300.19	Factitious Disorder NOS	B
	DISSOCIATIVE DISORDERS	
300.12	Dissociative Amnesia	B
300.13	Dissociative Fugue	B
300.14	Dissociative Identity Disorder	B
300.6	Depersonalization Disorder	B
300.15	Dissociative Disorder NOS	B
	SEXUAL AND GENDER IDENTITY DISORDERS	
	EATING DISORDERS	
307.1	Anorexia Nervosa	B
307.51	Bulimia Nervosa	B
307.50	Eating Disorder NOS	B
	ADJUSTMENT DISORDERS	
309.0	Adjustment Disorder With Depressed Mood	B
309.24	Adjustment Disorder With Anxiety	B
309.28	Adjustment Disorder With Mixed Anxiety and Depressed Mood	B
309.3	Adjustment Disorder With Disturbance of Conduct	B
309.4	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct	B
309.9	Adjustment Disorder Unspecified	B
	PERSONALITY DISORDERS	
301.0	Paranoid Personality Disorder	B
301.20	Schizoid Personality Disorder	B
301.22	Schizotypal Personality Disorder	B
301.7	Antisocial Personality Disorder	B
301.83	Borderline Personality Disorder	B
301.50	Histrionic Personality Disorder	B
301.81	Narcissistic Personality Disorder	B
301.82	Avoidant Personality Disorder	B
301.6	Dependent Personality Disorder	B
301.4	Obsessive-Compulsive Personality Disorder	B
301.9	Personality Disorder NOS	B

Additional Criteria for Diagnosis B

An individual with a "B" diagnosis must meet **at least one** of the following criteria to be considered for a level of care placement decision. Behaviors/symptoms must be the result of a mental illness.

* High Risk Behavior demonstrated during the previous 90 days – aggressive and/or dangerous, puts self or others at risk of harm, is at risk of grave disability, is at risk of psychiatric hospitalization or at risk of loss of current placement due to the symptoms of a mental illness
* Two or more hospital admissions due to a mental health diagnosis during the previous two years
* Psychiatric hospitalization or residential treatment due to a mental health diagnosis of more than six months duration in the previous year **OR** is currently being discharged from a psychiatric hospitalization
* Received public mental health treatment on an outpatient basis within the PIHP system during the previous 90 days and will deteriorate if services are not resumed (crisis intervention is not considered outpatient treatment)

Washington State Medicaid Program
Minimum Covered Diagnoses for Medicaid Children and Youth
1/1/06

Washington State defines acutely mentally ill, chronically mental ill adult, seriously disturbed person, and severely emotionally disturbed child in Chapters 71.24 and 71.05 RCW. The following diagnoses are considered to further interpret the statute criteria in establishing eligibility under the Washington State Medicaid Program. Additional eligibility requirements must be met to qualify for outpatient mental health services. Minimum eligibility requirements for authorization of services for Medicaid Children and Youth are further defined in the Access to Care Standards.

Please note: *The following covered diagnoses must be considered for coverage.*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	A = Covered B = Covered with Additional Criteria
	ATTENTION-DEFICIT AND DISRUPTIVE BEHAVIOR DISORDERS	
314.01	Attention-Deficit/Hyperactivity Disorder, Combined type	B
314.00	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type	B
314.01	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type	B
314.9	Attention-Deficit/Hyperactivity Disorder DOS	B
312.81	Conduct Disorder, Childhood-Onset Type	B
312.82	Conduct Disorder, Adolescent-Onset Type	B
312.89	Conduct Disorder, Unspecified Onset	B
313.81	Oppositional Defiant Disorder	B
312.9	Disruptive Behavior Disorder NOS	B
	OTHER DISORDERS OF INFANCY, CHILDHOOD, OR ADOLESCENCE	
309.21	Separation Anxiety Disorder	A
313.23	Selective Mutism	B
313.89	Reactive Attachment Disorder of Infancy or Early Childhood	B
307.3	Stereotypical Movement Disorder	B
313.9	Disorder of Infancy, Childhood, or Adolescence NOS	B

	SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	
295.30	Schizophrenia Paranoid Type	A
295.10	Schizophrenia Disorganized Type	A
295.20	Schizophrenia Catatonic Type	A
295.90	Schizophrenia Undifferentiated Type	A
295.60	Schizophrenia Residual Type	A
295.40	Schizophreniform Disorder	A
295.70	Schizoaffective Disorder	A
297.1	Delusional Disorder	A
298.8	Brief Psychotic Disorder	A
297.3	Shared Psychotic Disorder	A
293.81	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Delusions	A
293.82	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Hallucinations	A

298.9	Psychotic Disorder NOS	A
	MOOD DISORDERS	
	DEPRESSIVE DISORDERS	
296.22	Major Depressive Disorder Single Episode, Moderate	A
296.23	Major Depressive Disorder Single Episode, Severe Without Psychotic Features	A
296.24	Major Depressive Disorder Single Episode, Severe With Psychotic Features	A
296.25	Major Depressive Disorder Single Episode, In Partial Remission	A
296.26	Major Depressive Disorder Single Episode, In Full Remission	A
296.20	Major Depressive Disorder Single Episode, Unspecified	A
296.31	Major Depressive Disorder Recurrent, Mild	A
296.32	Major Depressive Disorder Recurrent, Moderate	A
296.33	Major Depressive Disorder Recurrent, Severe Without Psychotic Features	A
296.34	Major Depressive Disorder Recurrent, Severe With Psychotic Features	A
296.35	Major Depressive Disorder Recurrent, In Partial Remission	A
296.36	Major Depressive Disorder Recurrent, In Full Remission	A
296.30	Major Depressive Disorder Recurrent, Unspecified	A
300.4	Dysthymic Disorder	A
311	Depressive Disorder NOS	A
	BIPOLAR DISORDERS	
296.01	Bipolar I Disorder Single Manic Episode, Mild	A
296.02	Bipolar I Disorder Single Manic Episode, Moderate	A
296.03	Bipolar I Disorder Single Manic Episode, Severe Without Psychotic Features	A
296.04	Bipolar I Disorder Single Manic Episode, Severe With Psychotic Features	A
296.05	Bipolar I Disorder Single Manic Episode, In Partial Remission	A
296.06	Bipolar I Disorder Single Manic Episode, In Full Remission	A
296.00	Bipolar I Disorder Single Manic Episode, Unspecified	A
296.40	Bipolar I Disorder Most Recent Episode Hypomanic	A
296.41	Bipolar I Disorder Most Recent Episode Manic, Mild	A
296.42	Bipolar I Disorder Most Recent Episode Manic, Moderate	A
296.43	Bipolar I Disorder Most Recent Episode Manic, Severe Without Psychotic Features	A
296.44	Bipolar I Disorder Most Recent Episode Manic, Severe With Psychotic Features	A
296.45	Bipolar I Disorder Most Recent Episode Manic, In Partial Remission	A
296.46	Bipolar I Disorder Most Recent Episode Manic, In Full Remission	A
296.40	Bipolar I Disorder Most Recent Episode Manic, Unspecified	A
296.61	Bipolar I Disorder Most Recent Episode Mixed, Mild	A
296.62	Bipolar I Disorder Most Recent Episode Mixed, Moderate	A
296.63	Bipolar I Disorder Most Recent Episode Mixed, Severe Without Psychotic Features	A
296.64	Bipolar I Disorder Most Recent Episode Mixed, Severe With Psychotic Features	A
296.65	Bipolar I Disorder Most Recent Episode Mixed, In Partial Remission	A
296.66	Bipolar I Disorder Most Recent Episode Mixed, In Full Remission	A
296.60	Bipolar I Disorder Most Recent Episode Mixed, Unspecified	A
296.51	Bipolar I Disorder Most Recent Episode Depressed, Mild	A
296.52	Bipolar I Disorder Most Recent Episode Depressed, Moderate	A
296.53	Bipolar I Disorder Most Recent Episode Depressed, Severe Without Psychotic Features	A
296.54	Bipolar I Disorder Most Recent Episode Depressed, Severe With Psychotic Features	A
296.55	Bipolar I Disorder Most Recent Episode Depressed, In Partial Remission	A
296.56	Bipolar I Disorder Most Recent Episode Depressed, In Full Remission	A
296.50	Bipolar I Disorder Most Recent Episode Depressed, Unspecified	A
296.7	Bipolar I Disorder Most Recent Episode Unspecified	A
296.89	Bipolar II Disorder	A
301.13	Cyclothymic Disorder	B
296.80	Bipolar Disorder NOS	A
296.90	Mood Disorder NOS	A

	ANXIETY DISORDERS	
300.01	Panic Disorder Without Agoraphobia	A
300.21	Panic Disorder With Agoraphobia	A
300.22	Agoraphobia Without History of Panic Disorder	A
300.29	Specific Phobia	B
300.23	Social Phobia	B
300.3	Obsessive-Compulsive Disorder	A
309.81	Posttraumatic Stress Disorder	A
308.3	Acute Stress Disorder	A
300.02	Generalized Anxiety Disorder	A
300.00	Anxiety Disorder NOS	A
	SOMATOFORM DISORDERS	
300.81	Somatization Disorder	B
300.82	Undifferentiated Somatoform Disorder	B
300.11	Conversion Disorder	B
307.80	Pain Disorder Associated With Psychological Factors	B
307.89	Pain Disorder Associated With Both Psychological Factors and a General Medical Condition	B
300.7	Hypochondriasis	B
300.7	Body Dysmorphic Disorder	B
300.82	Somatoform Disorder NOS	B
	FACTITIOUS DISORDERS	
300.16	Factitious Disorder With Predominantly Psychological Signs and Symptoms	B
300.19	Factitious Disorder With Predominantly Physical Signs and Symptoms	B
300.19	Factitious Disorder With Combined Psychological and Physical Signs and Symptoms	B
300.19	Factitious Disorder NOS	B
	DISSOCIATIVE DISORDERS	
300.12	Dissociative Amnesia	B
300.13	Dissociative Fugue	B
300.14	Dissociative Identity Disorder	B
300.6	Depersonalization Disorder	B
300.15	Dissociative Disorder NOS	B
	SEXUAL AND GENDER IDENTITY DISORDERS	

	EATING DISORDERS	
307.1	Anorexia Nervosa	B
307.51	Bulimia Nervosa	B
307.50	Eating Disorder NOS	B
	ADJUSTMENT DISORDERS	
309.0	Adjustment Disorder With Depressed Mood	B
309.24	Adjustment Disorder With Anxiety	B
309.28	Adjustment Disorder With Mixed Anxiety and Depressed Mood	B
309.3	Adjustment Disorder With Disturbance of Conduct	B
309.4	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct	B
309.9	Adjustment Disorder Unspecified	B

	PERSONALITY DISORDERS	
301.0	Paranoid Personality Disorder	B
301.20	Schizoid Personality Disorder	B
301.22	Schizotypal Personality Disorder	B
301.7	Antisocial Personality Disorder	B
301.83	Borderline Personality Disorder	B
301.50	Histrionic Personality Disorder	B
301.81	Narcissistic Personality Disorder	B
301.82	Avoidant Personality Disorder	B
301.6	Dependent Personality Disorder	B
301.4	Obsessive-Compulsive Personality Disorder	B
301.9	Personality Disorder NOS	B

Additional Criteria for Diagnosis B

An individual with a "B" diagnosis must meet **at least one** of the following criteria to be considered for a level of care placement decision. Behaviors/symptoms must be the result of a mental illness.
[Please note: CGAS is generally not considered valid for children under the age of six. The DC03 may be substituted. Children under six are exempted from Axis V scoring. Very young children in need of mental health care may not readily fit diagnostic criteria. The degree of functional impairment related to the symptoms of an emotional disorder or mental illness should determine eligibility. Functional impairment for very young children is described in the last bullet.]

- High-Risk Behavior demonstrated during the previous 90 days – aggressive and/or dangerous, puts self or others at risk of harm, is at risk of severe functional deterioration, is at risk of hospitalization or at risk of loss of current placement due to mental illness or at risk of out of home placement due to the symptoms of an emotional disorder or mental illness
- At risk of escalating symptoms due to repeated physical or sexual abuse or neglect and there is significant impairment in the adult caregiver's ability to adequately address the child's needs
- Two or more hospital admissions due to a mental health diagnosis during the previous two years
- Psychiatric hospitalization or residential treatment due to a mental health diagnosis of more than six months duration in the previous year **OR** is currently being discharged from a psychiatric hospitalization
- Received public mental health treatment on an outpatient basis within the PIHP system during the previous 90 days and will deteriorate if services are not resumed (crisis intervention is not considered outpatient treatment)
- Child is under six years of age and there is a severe emotional abnormality in the child's overall functioning as indicated by one of the following:
    1. Atypical behavioral patterns as a result of an emotional disorder or mental illness (odd disruptive or dangerous behavior which is aggressive, self injurious, or hypersexual; display of indiscriminate sociability/excessive familiarity with strangers).
    2. Atypical emotional response patterns as a result of an emotional disorder or mental illness which interferes with the child's functioning (e.g., inability to communicate emotional needs; inability to tolerate age-appropriate frustrations; lack of positive interest in adults and peers or a failure to initiate or respond to most social interaction; fearfulness or other distress that doesn't respond to comfort from caregivers).

Additional Criteria for Diagnosis B for Children Age Six and Older

Client Name:_____ **Date:** _____

Agency Case ID:_____ **Staff Initials:**_____

When case rate authorization or any other non-crisis outpatient program except Interagency Staffing Team is requested for a child who has only a B diagnosis, at least one additional criterion must be met. To document that a client fulfills one of these criteria, use the following checklist. One checked box is sufficient for the additional criteria to be met.

1. The client received public mental health treatment on an outpatient basis within the Prepaid Inpatient Health Plan system during the previous 90 days and their mental health condition will deteriorate if services are not resumed (crisis intervention is not considered outpatient treatment).
   - ☐ For clients who have most recently received services in King County Regional Support Network, the client has had an open authorization to one of the following services or programs within the last 90 days: case rate of 2X, 3A or 3B, MST, FFT, and FIT.
   - ☐ For clients who have most recently received non-crisis services through another RSN, the client has had an open authorization within the last 90 days. Please provide the name of the RSN and the last date of the authorization.

     RSN_____ Last date of authorization_____

2. High-Risk Behavior demonstrated during the previous 90 days: aggressive and/or dangerous, puts self or others at risk of harm, is at risk of grave disability, is at risk of psychiatric hospitalization, or at risk of loss of current placement due to the symptoms of a mental illness.
   - ☐ Client has demonstrated dangerousness to self.
   - ☐ Client has demonstrated dangerousness to others.
   - ☐ Client has compromised his/her health and/or safety to the point of nearing grave disability.
   - ☐ Client has been admitted to a psychiatric hospital.
   - ☐ Client has required one or more of the following crisis services: Crisis and Commitment Services, Children's Crisis Outreach Response, crisis stabilization bed, inpatient diversion bed, or developmental disabilities crisis bed.
   - ☐ Client has lost his/her home/placement due to mental illness.
   - ☐ Client is at risk of loss of home/placement (examples: escalation of undesirable behaviors in a foster home, group home, or family home, Children's Protective Service involvement, Department of Child and Family Services (DCFS) involvement)

3. Two or more hospital admissions due to a mental health diagnosis during the previous two years.
   - ☐ Client has had at least two separate admissions for inpatient psychiatric care on an acute and emergent basis during the last two years. Hospital can be in any location and payment may have been with any payer. A transfer from one hospital to another counts as a single admission. A revocation of a less restrictive order when a person is an outpatient counts as an additional hospitalization even though it is on the same court order. If a person's status changes between voluntary and involuntary during a single admission, this counts as a single admission.

4. Currently being discharged from a psychiatric hospitalization.

   ☐ Client is being discharged from inpatient psychiatric care (acute and emergent) within the upcoming 30 days or was discharged within the last 30 days. Hospital can be in any location and payment may have been with any payer.

5. Psychiatric hospitalization or residential treatment (due to a mental health diagnosis) of more than six months duration in the previous year.

   ☐ Client has been in a hospital and/or residential program for 180 continuous days. These days may be a combination of hospital AND residential days. Residential facilities include therapeutic foster care, DCFS group care, Behavioral Rehabilitation Services (examples: Ryther, Ruth Dykeman, Cobb, some Service Alternatives homes, some JRA residential treatment settings such as Griffin).

6. At risk of escalating symptoms due to repeated physical or sexual abuse or neglect and there is significant impairment in the adult caregiver's ability to adequately address the child's needs.

   ☐ Client has or is experiencing repeated physical abuse, sexual abuse, or neglect AND is having mental health symptoms because of the abuse or neglect AND the adult caregiver is unable to provider for the child's safety and/or the child's treatment needs.

Additional Criteria for Diagnosis B for Adults and Older Adults

Client Name:_____ **Date:**_____

Agency Case ID:_____ **Staff Initials:**_____

When case rate authorization or any other non-crisis outpatient service except HOST/PATH is requested for an adult or older adult who has only a B diagnosis, at least one additional criterion must be met. To document that a client fulfills one of these criteria, use the following checklist. One box is sufficient for the "additional criteria" to be met.

1. The client received public mental health treatment on an outpatient basis within the Prepaid Inpatient Health Plan system during the previous 90 days and their mental health condition will deteriorate if services are not resumed (crisis intervention is not considered outpatient treatment).
   - ☐ For clients who have most recently received services in King County Regional Support Network (RSN), the client has had an open authorization for one of the following services or programs within the last 90 days: case rate of 2X, 3A or 3B, Long-term rehabilitation (LTR), HOST/PATH, COD, FIRST (formerly MIO/CTP), Mental health voucher, Expanded Community Services-Intensive Community Support and Recovery Program (ECS-ICSRP, or Western State Hospital-Intensive Community Support (WSH-ICS).
   - ☐ For clients who have most recently received non-crisis services through another RSN, the client has had an open authorization within the last 90 days. Please provide the name of the RSN and the last date of the authorization.

     RSN_____ Last date of authorization_____

2. High-Risk Behavior demonstrated during the previous 90 days: aggressive and/or dangerous, puts self or others at risk of harm, is at risk of grave disability, is at risk of psychiatric hospitalization, or at risk of loss of current placement due to the symptoms of a mental illness.
   - ☐ Client has demonstrated dangerousness to self.
   - ☐ Client has demonstrated dangerousness to others.
   - ☐ Client has compromised his/her health and/or safety to the point of nearing grave disability.
   - ☐ Client has been admitted to a psychiatric hospital.
   - ☐ Client has used at least one of the following crisis services: Crisis and Commitment Services, Downtown Emergency Services Center respite bed, inpatient diversion bed (at Cascade Hall or Transitional Resources), Mental health detox, Developmental disabilities crisis bed (at Cascade Hall).
   - ☐ Client has lost his/her home/placement due to mental illness.
   - ☐ Client is at risk of loss of home/placement (examples: eviction notice, requirement for increased in home services, escalation of undesirable behaviors in a nursing home).

3. Two or more hospital admissions due to a mental health diagnosis during the previous two years.
   - ☐ Client has had at least two separate admissions for inpatient psychiatric care on an acute and emergent basis during the last two years. Hospital can be in any location and payment may have been with any payer. A transfer from one hospital to another counts as a single admission. A revocation of a less restrictive order when a person is an outpatient counts as an additional hospitalization even though it is on the same court order. If a person's status changes between voluntary and involuntary during a single admission, this counts as a single admission.

4. Currently being discharged from a psychiatric hospitalization.
   - ☐ Client is being discharged from inpatient psychiatric care (acute and emergent) within the upcoming 30 days or was discharged within the last 30 days. Hospital can be in any location and payment may have been with any payer.

5. Psychiatric hospitalization or residential treatment due to a mental health diagnosis of more than six months duration in the previous year.
   - ☐ Client has been in a hospital and/or residential program for 180 continuous days. These days may be a combination of hospital AND residential days.

NON-MEDICAID OUTPATIENT BENEFIT REQUEST
(Form for Agencies with a Quarterly Allocation)

Date Requested: _____

Client Name: _____

KCID: _____

Case Rate Requested: _____

Provider Code: _____

Referring person: _____

Referring person phone number: _____

Please indicate if this request is for a person in a First Priority population (check one after referring to 3.2.5 in this Section)

☐ State hospital or CLIP discharge

Date admitted to Western State Hospital (WSH): _____

Date being discharged from WSH: _____

Date admitted to Child Study and Treatment Center (CSTC), McGraw Center, Pearl Street Center, or Tamarack: _____

Date being discharged from CSTC, McGraw Center, Pearl Street Center, or Tamarack: _____

☐ Release from incarceration

Date admitted to prison or juvenile rehabilitation facility: _____

Date being discharged from prison or juvenile rehabilitation facility: _____

Date Medicaid application initiated: _____

Date Medicaid application expected to be complete: _____

☐ Extraordinary Treatment Plan

☐ Housing (person is in SSH, ISH, or ShelterPlusCare)

If not in a First Priority population, please indicate a Second Priority population (check one)

☐ Community hospital discharge

☐ Discharge from PACT

Date of PACT graduation _____

☐ Current non-Medicaid benefit with Medicaid application pending

☐ Admissions/incarcerations/detentions in past 12 months with referral from a suburban jail liaison

Date of discharge or release _____

☐ Exception to the above

Rationale for exception _____

_____

_____

Medical Necessity justification, including CGAS/GAF score justification:

_____

_____

_____

_____

_____

_____

_____

_____

NON-MEDICAID OUTPATIENT BENEFIT REQUEST
(Form for Agencies without a Quarterly Allocation)

Date Requested: _____

Client Name: _____

KCID: _____

Case Rate Requested: _____

Provider Code: _____

Referring person: _____

Referring person phone number: _____

Please indicate if this request is for a person in a First Priority population (check one after referring to 3.2.5 in this Section)

☐ State hospital or CLIP discharge

Date admitted to Western State Hospital (WSH): _____

Date being discharged from WSH: _____

Date admitted to Child Study and Treatment Center (CSTC), McGraw Center, Pearl Street Center, or Tamarack: _____

Date being discharged from CSTC, McGraw Center, Pearl Street Center, or Tamarack: _____

☐ Release from incarceration

Date admitted to prison or juvenile rehabilitation facility: _____

Date being discharged from prison or juvenile rehabilitation facility: _____

Date Medicaid application initiated: _____

Date Medicaid application expected to be complete: _____

☐ Extraordinary Treatment Plan

☐ Housing (person is in SSH, ISH, or ShelterPlusCare)

If not in a First Priority population, please indicate a Second Priority population (check one)

☐ Housing (in LTR or SL stepping down to SSH)

☐ Community hospital discharge

☐ Homeless

☐ Discharge from PACT

Date of PACT graduation _____

☐ 3B

☐ 3A

Specify age _____

☐ Refugees, immigrants, or their children

☐ Medicare qualifiers

☐ Current non-Medicaid benefit with Medicaid application pending

☐ Admissions/incarcerations/detentions in past 12 months

Date of discharge or release _____

☐ Exception to the above

Rationale for exception _____

_____

_____

Medical Necessity justification, including CGAS/GAF score justification:

_____

_____

_____

_____

_____

_____

_____

Non-Medicaid Access Diagnosis Codes

(for persons referred upon discharge from inpatient care)

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	ICD-9-CM 2002 DEFINITION	ICD-9-CM 2002 CODE	
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS				
295.30	Schizophrenia Paranoid Type	Schizophrenic disorder, paranoid type, unspecified	295.30	
295.10	Schizophrenia Disorganized Type	Schizophrenic disorder, disorganized type, unspecified	295.10	
295.20	Schizophrenia Catatonic Type	Schizophrenic disorder, catatonic type, unspecified	295.20	
295.90	Schizophrenia Undifferentiated Type	Schizophrenic disorder, unspecified, unspecified	295.90	
295.60	Schizophrenia Residual Type	Residual schizophrenia, unspecified	295.60	
295.40	Schizophreniform Disorder	Acute schizophrenic episode, unspecified	295.40	
295.70	Schizoaffective Disorder	Schizo-affective type, unspecified	295.70	
297.1	Delusional Disorder	Paranoia	297.1	
298.8	Brief Psychotic Disorder	Other and unspecified reactive psychosis	298.8	
297.3	Shared Psychotic Disorder	Shared paranoid disorder	297.3	
298.9	Psychotic Disorder NOS	Unspecified psychosis	298.9	
		Schizophrenic disorder, simple type, unspecified	295.00	*
		Schizophrenic disorder, simple type, subchronic	295.01	*
		Schizophrenic disorder, simple type, chronic	295.02	*
		Schizophrenic disorder, simple type, subchronic with acute exacerbation	295.03	*
		Schizophrenic disorder, simple type, chronic with acute exacerbation	295.04	*
		Schizophrenic disorder, simple type, in remission	295.05	*
		Schizophrenic disorder, disorganized type, subchronic	295.11	*
		Schizophrenic disorder, disorganized type, chronic	295.12	*
		Schizophrenic disorder, disorganized type, subchronic with acute exacerbation	295.13	*
		Schizophrenic disorder, disorganized type, chronic with acute exacerbation	295.14	*
		Schizophrenic disorder, disorganized type, in remission	295.15	*
		Schizophrenic disorder, catatonic type, subchronic	295.21	*
		Schizophrenic disorder, catatonic type, chronic	295.22	*
		Schizophrenic disorder, catatonic type,	295.23	*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	ICD-9-CM 2002 DEFINITION	ICD-9-CM 2002 CODE	
		subchronic with acute exacerbation		
		Schizophrenic disorder, catatonic type, chronic with acute exacerbation	295.24	*
		Schizophrenic disorder, catatonic type, in remission	295.25	*
		Schizophrenic disorder, paranoid type, subchronic	295.31	*
		Schizophrenic disorder, paranoid type, chronic	295.32	*
		Schizophrenic disorder, paranoid type, subchronic with acute exacerbation	295.33	*
		Schizophrenic disorder, paranoid type, chronic with acute exacerbation	295.34	*
		Schizophrenic disorder, paranoid type, in remission	295.35	*
		Schizophrenic disorder, latent schizophrenia, unspecified	295.50	*
		Schizophrenic disorder, latent schizophrenia, subchronic	295.51	*
		Schizophrenic disorder, latent schizophrenia, chronic	295.52	*
		Schizophrenic disorder, latent schizophrenia, subchronic with acute exacerbation	295.53	*
		Schizophrenic disorder, latent schizophrenia, chronic with acute exacerbation	295.54	*
		Schizophrenic disorder, latent schizophrenia, in remission	295.55	*
		Schizophrenic disorder, residual schizophrenia, subchronic	295.61	*
		Schizophrenic disorder, residual schizophrenia, chronic	295.62	*
		Schizophrenic disorder, residual schizophrenia, subchronic with acute exacerbation	295.63	*
		Schizophrenic disorder, residual schizophrenia, chronic with acute exacerbation	295.64	*
		Schizophrenic disorder, residual schizophrenia, in remission	295.65	*
		Schizophrenic disorder, schizoaffective type, subchronic	295.71	*
		Schizophrenic disorder, schizoaffective type, chronic	295.72	*
		Schizophrenic disorder, schizoaffective type, subchronic with acute exacerbation	295.73	*
		Schizophrenic disorder,	295.74	*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	ICD-9-CM 2002 DEFINITION	ICD-9-CM 2002 CODE	
		schizoaffective type, chronic with acute exacerbation		
		Schizophrenic disorder, schizoaffective type, in remission	295.75	*
		Schizophrenic disorder, other specified types of schizophrenia, unspecified	295.80	*
		Schizophrenic disorder, other specified types of schizophrenia, subchronic	295.81	*
		Schizophrenic disorder, other specified types of schizophrenia, chronic	295.82	*
		Schizophrenic disorder, other specified types of schizophrenia, subchronic with acute exacerbation	295.83	*
		Schizophrenic disorder, other specified types of schizophrenia, chronic with acute exacerbation	295.84	*
		Schizophrenic disorder, other specified types of schizophrenia, in remission	295.85	*
		Schizophrenic disorder, unspecified, subchronic	295.91	*
		Schizophrenic disorder, unspecified, chronic	295.92	*
		Schizophrenic disorder, unspecified, subchronic with acute exacerbation	295.93	*
		Schizophrenic disorder, unspecified, chronic with acute exacerbation	295.94	*
		Schizophrenic disorder, unspecified, in remission	295.95	*
		Paranoid state, simple	297.0	*
		Paraphrenia	297.2	*
		Acute paranoid reaction	298.3	*
BIPOLAR DISORDERS				
296.01	Bipolar I Disorder Single Manic Episode, Mild	Manic disorder, single episode, mild	296.01	
296.02	Bipolar I Disorder Single Manic Episode, Moderate	Manic disorder, single episode, moderate	296.02	
296.03	Bipolar I Disorder Single Manic Episode, Severe Without Psychotic Features	Manic disorder, single episode, severe, without mention of psychotic behavior	296.03	
296.04	Bipolar I Disorder Single Manic Episode, Severe With Psychotic Features	Manic disorder, single episode, severe, specified as with psychotic behavior	296.04	
296.05	Bipolar I Disorder Single Manic Episode, In Partial Remission	Manic disorder, single episode, impartial or unspecified remission	296.05	
296.06	Bipolar I Disorder Single Manic Episode, In Full Remission	Manic disorder, single episode, in full remission	296.06	
296.00	Bipolar I Disorder Single	Manic disorder, single episode,	296.00	

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	ICD-9-CM 2002 DEFINITION	ICD-9-CM 2002 CODE	
	Manic Episode, Unspecified	unspecified		
296.40	Bipolar I Disorder Most Recent Episode Hypomanic	Bipolar affective disorder, manic, unspecified	296.40	
296.41	Bipolar I Disorder Most Recent Episode Manic, Mild	Bipolar affective disorder, manic, mild	296.41	
296.42	Bipolar I Disorder Most Recent Episode Manic, Moderate	Bipolar affective disorder, manic, moderate	296.42	
296.43	Bipolar I Disorder Most Recent Episode Manic, Severe Without Psychotic Features	Bipolar affective disorder, manic, severe, without mention of psychotic behavior	296.43	
296.44	Bipolar I Disorder Most Recent Episode Manic, Severe With Psychotic Features	Bipolar affective disorder, manic, severe, specified as with psychotic behavior	296.44	
296.45	Bipolar I Disorder Most Recent Episode Manic, In Partial Remission	Bipolar affective disorder, manic, in partial or unspecified remission	296.45	
296.46	Bipolar I Disorder Most Recent Episode Manic, In Full Remission	Bipolar affective disorder, manic, in full remission	296.46	
296.40	Bipolar I Disorder Most Recent Episode Manic, Unspecified	Bipolar affective disorder, manic, unspecified	296.40	
296.61	Bipolar I Disorder Most Recent Episode Mixed, Mild	Bipolar affective disorder, mixed, mild	296.61	
296.62	Bipolar I Disorder Most Recent Episode Mixed, Moderate	Bipolar affective disorder, mixed, moderate	296.62	
296.63	Bipolar I Disorder Most Recent Episode Mixed, Severe Without Psychotic Features	Bipolar affective disorder, mixed, severe, without mention of psychotic behavior	296.63	
296.64	Bipolar I Disorder Most Recent Episode Mixed, Severe With Psychotic Features	Bipolar affective disorder, mixed, severe, specified as with psychotic behavior	296.64	
296.65	Bipolar I Disorder Most Recent Episode Mixed, In Partial Remission	Bipolar affective disorder, mixed, in partial or unspecified remission	296.65	
296.66	Bipolar I Disorder Most Recent Episode Mixed, In Full Remission	Bipolar affective disorder, mixed, in full remission	296.66	
296.60	Bipolar I Disorder Most Recent Episode Mixed, Unspecified	Bipolar affective disorder, mixed, unspecified	296.60	
296.51	Bipolar I Disorder Most Recent Episode Depressed, Mild	Bipolar affective disorder, depressed, mild	296.51	
296.52	Bipolar I Disorder Most Recent Episode Depressed, Moderate	Bipolar affective disorder, depressed, moderate	296.52	

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	ICD-9-CM 2002 DEFINITION	ICD-9-CM 2002 CODE	
296.53	Bipolar I Disorder Most Recent Episode Depressed, Severe Without Psychotic Features	Bipolar affective disorder, depressed, severe, without mention of psychotic behavior	296.53	
296.54	Bipolar I Disorder Most Recent Episode Depressed, Severe With Psychotic Features	Bipolar affective disorder, depressed, severe, specified as with psychotic behavior	296.54	
296.55	Bipolar I Disorder Most Recent Episode Depressed, In Partial Remission	Bipolar affective disorder, depressed, in partial or unspecified remission	296.55	
296.56	Bipolar I Disorder Most Recent Episode Depressed, In Full Remission	Bipolar affective disorder, depressed, in full remission	296.56	
296.50	Bipolar I Disorder Most Recent Episode Depressed, Unspecified	Bipolar affective disorder, depressed, unspecified	296.50	
296.7	Bipolar I Disorder Most Recent Episode Unspecified	Bipolar affective disorder, unspecified	296.7	
		Manic disorder, recurrent episode, unspecified	296.10	*
		Manic disorder, recurrent episode, mild	296.11	*
		Manic disorder, recurrent episode, moderate	296.12	*
		Manic disorder, recurrent episode, severe, without mention of psychotic behavior	296.13	*
		Manic disorder, recurrent episode, severe, specified as with psychotic behavior	296.14	*
		Manic disorder, recurrent episode, in partial or unspecified remission	296.15	*
		Manic disorder, recurrent episode, in full remission	296.16	*
DEPRESSIVE DISORDERS				
296.24	Major Depressive Disorder Single Episode, Severe With Psychotic Features	Major depressive disorder, single episode, severe, specified as with psychotic behavior	296.24	
296.34	Major Depressive Disorder Recurrent, Severe With Psychotic Features	Major depressive disorder, recurrent episode, severe, specified as with psychotic behavior	296.34	

*These codes are ICD-9, not DSM-IV, diagnostic codes and, at this time, are not accepted diagnoses in our outpatient system. However, since hospitals use ICD-9 codes, a referred discharged patient may have one of these disallowed codes and no eligible DSM diagnosis. To avoid uncertainty about whether a person will be eligible for care: any person with any code on this list given at the hospital on discharge, starred or not, fulfills the diagnostic criteria for a non-Medicaid benefit.

Case Rate Criteria for Routine Outpatient Services
King County Regional Support Network/Mental Health Plan

Purpose:
The Case Rate Criteria document contains the minimum requirements, by benefit and by age group, which a person must meet in order for the provider to receive a particular case rate under the King County Mental Health Plan (KCMHP). It specifies the level of functioning, degree of psychiatric impairment, expected service intensity, and expected outcomes and benefit period for each case rate.

The application of the case rate criteria requires a formal, face-to-face assessment process that results in an outpatient authorization request from the provider to the KCMHP. Adults shall be assessed using the criteria from the Global Assessment of Functioning (GAF) Scale. Children under six years of age shall be assessed using the case rate criteria. Children between the ages of 6 and 18 shall use the criteria that consider Children's Global Assessment Scale (CGAS) scores. Children between the ages of 18 and 21 shall have the option of being assessed for eligibility for either the adult or children's systems, but shall use the criteria that considers the GAF Scale scores.

For assistance in determining which case rate to request, see the decision trees in Attachment G of this Section.

For assessment tools (GAF and CGAS) to assist in the determination of medical necessity, see Attachment H of this Section.

I. Case Rate Criteria – Outpatient Children

2X Case Rate: Stability Services

Description:
Treatment or services to establish, improve, or stabilize level of functioning for children who require, at a minimum, occasional supervision.

Admission Criteria:
Must meet Access to Care criteria as described in Section VI, 3.2.2

Expected Outcome(s):
1. Improvement/stabilization of psychiatric symptoms.
2. Improvement/stabilization of level of functioning.
3. Prevention of psychiatric hospitalization.
4. Prevention of juvenile detention.
5. Prevention of homelessness.
6. Prevention of school suspension.
7. Prevention of out-of-home placement.

Benefit Period: 365 days

I. Case Rate Criteria – Outpatient Children (continued)

3A Case Rate: Rehabilitation

Description:
Active rehabilitation and/or intervention services to stabilize or improve a child's level of functioning or to prevent deterioration below 3A level of functioning. The child may have or need multi-system involvement, although this is not a requirement.

Admission Criteria:

For children younger than age 6:
Must meet Access to Care criteria as described in Section VI, 3.2.2

For children from ages 6 through 17:
1. Must meet Access to Care criteria as described in Section VI, 3.2.2 **and**
2. Axis V CGAS less than 51.

For children from ages 18 through 20:
1. Must meet Access to Care criteria as described in Section VI, 3.2.2; **and**
2. Axis V GAF less than 51.

Expected Outcome(s):
1. Improvement/stabilization of psychiatric symptoms.
2. Improvement/stabilization of level of functioning.
3. Prevention of psychiatric hospitalization.
4. Prevention of juvenile detention.
5. Prevention of homelessness.
6. Prevention of school suspension.
7. Prevention of out-of-home placement.

Benefit Period: 365 days

I. Case Rate Criteria – Outpatient Children (continued)

3B Case Rate: Exceptional Care

Description:
Consistent, intensive, long-term services to improve functioning or stabilize in the community for children who are severely impaired and for whom lack of treatment would result in serious dysfunction, failure in functioning, or involvement in more restrictive treatment.

Admission Criteria:

For children younger than age 6:

1. Must meet Access to Care criteria as described in Section VI, 3.2.2; and
2. Have a severe developmental abnormality in the child's overall functioning as manifested by one of the following:
   a. Atypical, odd, disruptive or dangerous behavior which is aggressive or self-injurious;
   b. Atypical emotional responses which interfere with the child's functioning, such as an inability to communicate emotional needs and to tolerate normal frustrations;
   c. Atypical thinking patterns which, considering age and developmental expectations, are bizarre, violent, or hypersexual;
   d. Lack of positive interests in adults and peers or a failure to initiate or respond to most social interaction;
   e. Indiscriminate sociability, for example, excessive familiarity with strangers; **or**
   f. Fearfulness or other distress which does not respond to comfort by caregivers.
3. Past behavior pattern shows a chronic, high level of danger to self or others, property damage, disruption, oppositionality, or conduct difficulties.
   a. For children under age 3, this includes prolonged states of dysregulation and distress that are interfering with developmental progression, growth, and/or the establishment of a healthy, functional relationship with a primary caregiver, and that cannot be explained by a medical problem.

For children from ages 6 through 17:

1. Must meet Access to Care criteria as described in Section VI, 3.2.2; and
2. Axis V CGAS less than 41; and
3. Past behavior pattern shows a chronic, high level of danger to self or others, property damage, disruption, oppositionality, or conduct difficulties.

For children from ages 18 through 20:

1. Must meet Access to Care criteria as described in Section VI, 3.2.2; and
2. Axis V GAF less than 31; and
3. Past behavior pattern shows a chronic, high level of danger to self or others, property damage, disruption, oppositionality, or conduct difficulties.

I. Case Rate Criteria – Outpatient Children (continued)

3B Case Rate: Exceptional Care

Expected Outcome(s):
1. Improvement/stabilization of psychiatric symptoms.
2. Improvement/stabilization of level of functioning.
3. Prevention of psychiatric hospitalization.
4. Prevention of juvenile detention.
5. Prevention of homelessness.
6. Prevention of school suspension.
7. Prevention of out-of-home placement.

Benefit Period: 365 days

II. Case Rate Criteria – Outpatient Adults

2X Case Rate: Stability Services

Description:
Treatment or services to assist an adult to establish, improve, or stabilize his or her level of functioning. This case rate applies to adults who require, at a minimum, occasional supervision.

Admission Criteria:
Must meet Access to Care criteria as described in Section VI, 3.2.2

Expected Outcome(s):
1. Maintenance/stabilization in psychiatric symptoms.
2. Maintenance/stabilization in level of functioning.
3. Prevention of psychiatric hospitalization.
4. Prevention of incarceration.
5. Prevention of homelessness.
6. Engagement in structured activities outside the mental health center.

Benefit Period: 365 days

II. Case Rate Criteria – Outpatient Adults (continued)

3A Case Rate: Rehabilitation

Description:
Active rehabilitation and/or intervention services to assist an adult to stabilize or improve his or her level of functioning or to prevent deterioration below 3A level of functioning.

Admission Criteria:
1. Must meet Access to Care criteria as described in Section VI, 3.2.2; **and**
2. Level of functioning Axis V GAF less than 51.

Expected Outcome(s):
1. Improvement/stabilization of psychiatric symptoms.
2. Improvement/stabilization in level of functioning.
3. Prevention of psychiatric hospitalization.
4. Prevention of incarceration.
5. Prevention of homelessness.
6. Engagement in structured activities outside the mental health center.

Benefit Period: 365 days

II. Case Rate Criteria – Outpatient Adults (continued)

3B Case Rate: Exceptional Care

Description:
Consistent, intensive, long-term services to assist an adult to improve her or his functioning or to stabilize in the community. This case rate applies for adults who are severely impaired and for whom lack of treatment would result in serious dysfunction, failure in functioning, or involvement in more restrictive treatment.

Admission Criteria:
1. Must meet Access to Care criteria as described in Section VI, 3.2.2; **and**
2. Level of functioning Axis V GAF less than 31.

Expected Outcome(s):
1. Improvement/stabilization of psychiatric symptoms.
2. Improvement/stabilization in level of functioning.
3. Prevention of psychiatric hospitalization.
4. Prevention of incarceration.
5. Prevention of homelessness.
6. Engagement in structured activities outside the mental health center.

Benefit Period: 365 days

III. Case Rate Criteria – Outpatient Older Adults

2X Case Rate: Stability Services

Description:
Treatment or services to assist an older adult (and his or her caregivers, if indicated) to establish, improve, or stabilize his or her level of functioning. This case rate applies for older adults who require, at a minimum, occasional supervision.

Admission Criteria:
Must meet Access to Care criteria as described in Section VI, 3.2.2

Expected Outcome(s):
1. Improvement/stabilization of psychiatric symptoms.
2. Improvement/stabilization in level of functioning.
3. Prevention of psychiatric hospitalization.
4. Prevention of incarceration.
5. Prevention of homelessness.
6. Linkage with medical system.

Benefit Period: 365 days

III. Case Rate Criteria – Outpatient Older Adults (continued)

3A Case Rate: Rehabilitation

Description:
Active rehabilitation and/or intervention services to assist an older adult (and his or her caregivers, if indicated) to stabilize or improve her or his level of functioning or to prevent deterioration below 3A level of functioning.

Admission Criteria:
1. Must meet Access to Care criteria as described in Section VI, 3.2.2; **and**
2. Level of functioning Axis V GAF less than 51.

Expected Outcome(s):
1. Improvement/stabilization of psychiatric symptoms.
2. Improvement/stabilization of level of functioning.
3. Prevention of psychiatric hospitalization.
4. Prevention of incarceration.
5. Prevention of homelessness.
6. Linkage with medical system.

Benefit Period: 365 days

III. Case Rate Criteria – Outpatient Older Adults (continued)

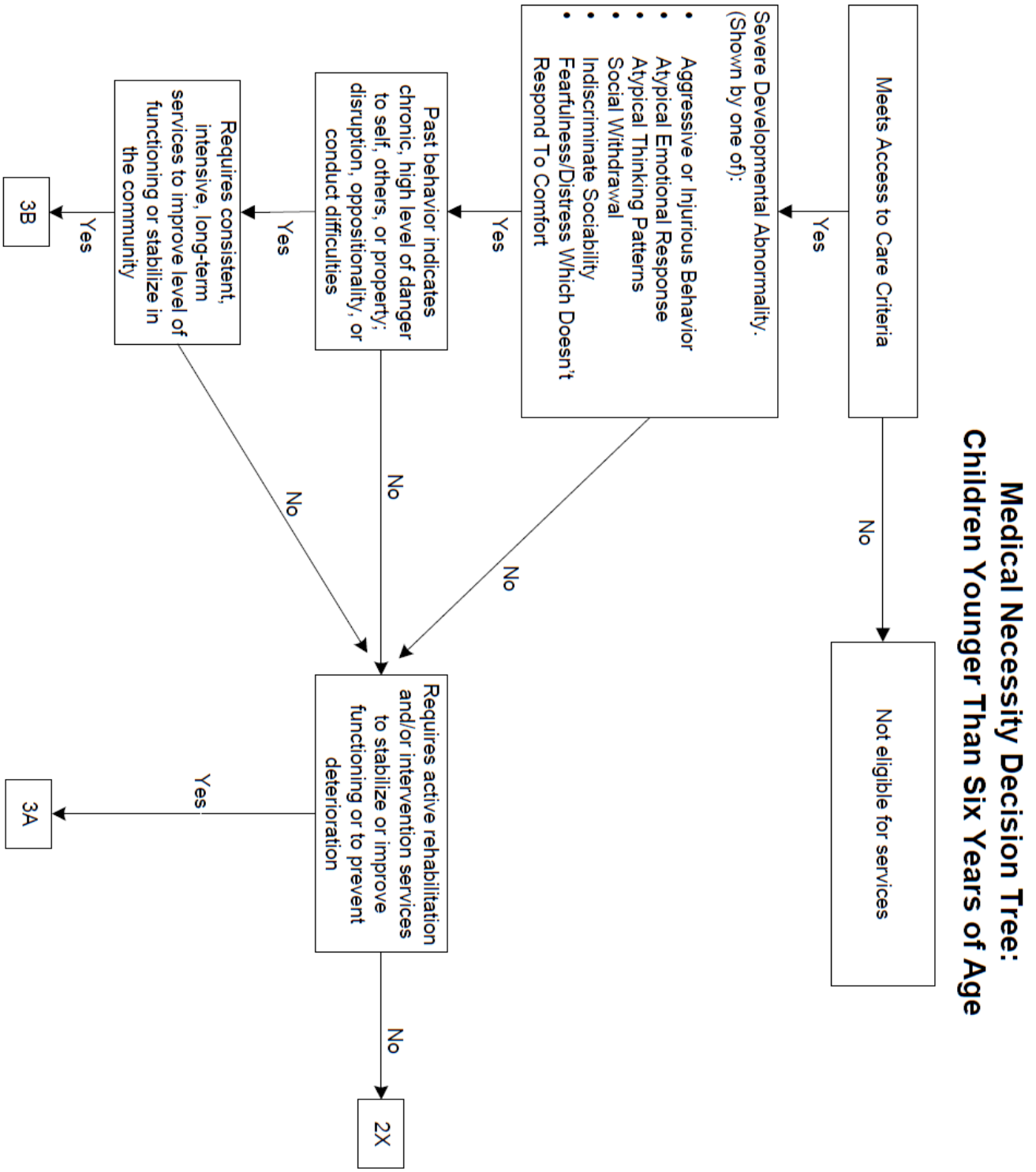
3B Case Rate: Exceptional Care

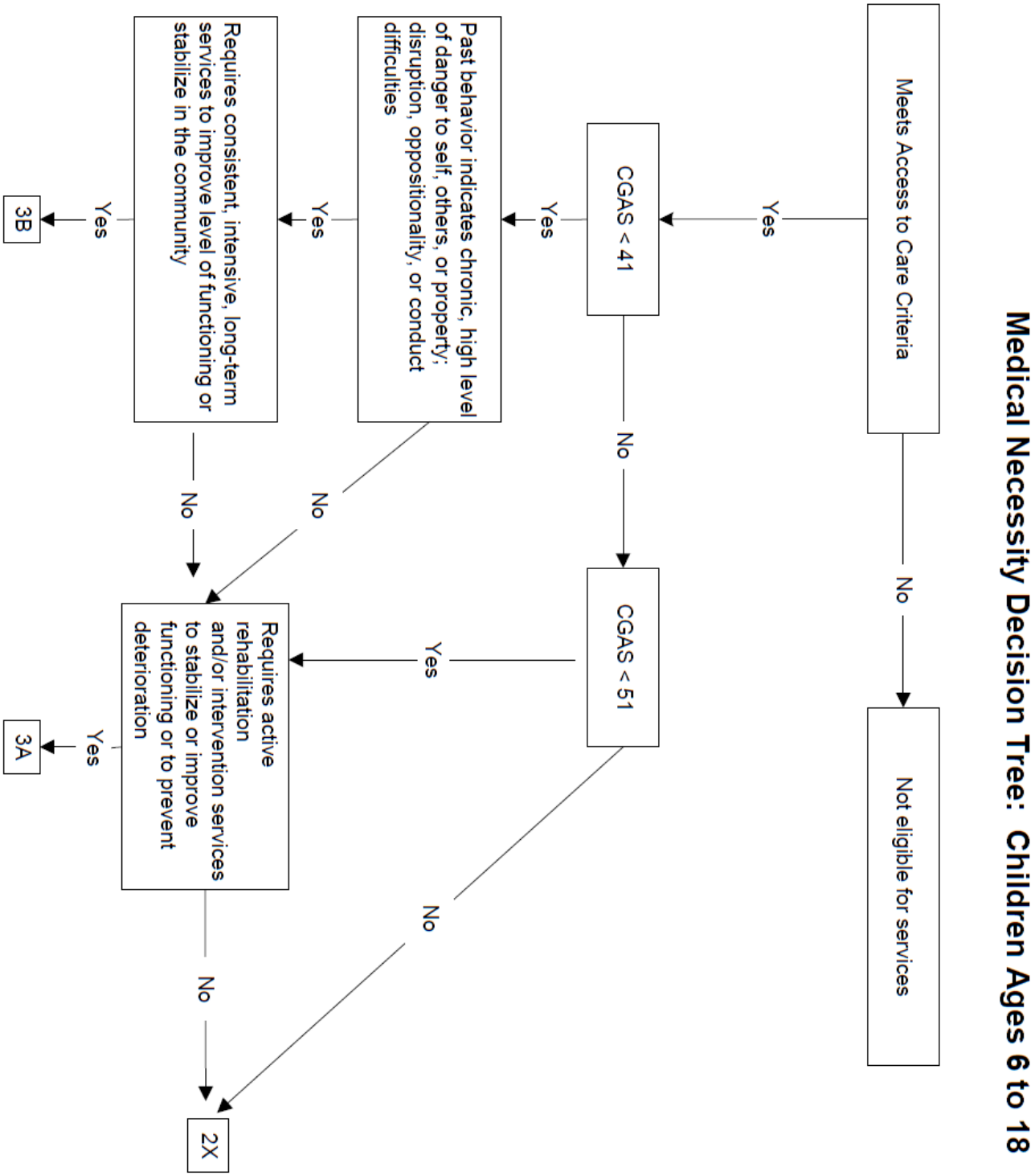
Description:
Consistent, intensive, long-term services to assist an older adult (and his or her caregivers, if indicated) to improve his or her functioning or to stabilize in the community. This case rate applies to older adults who are severely impaired and for whom lack of treatment would result in serious dysfunction, failure in functioning, or involvement in more restrictive treatment.

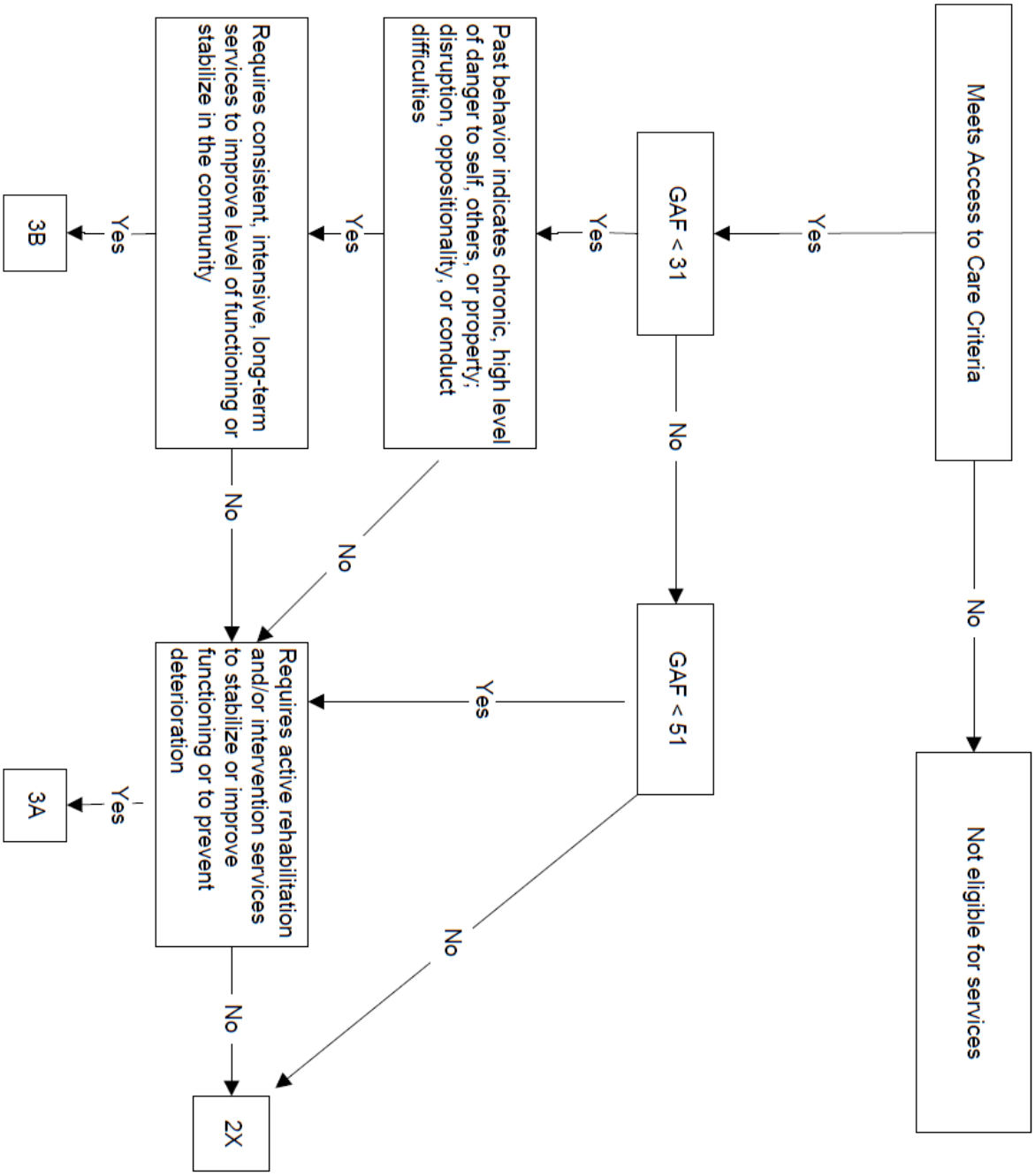
Admission Criteria:
1. Must meet Access to Care criteria as described in Section VI, 3.2.2; **and**
2. Level of functioning Axis V GAF less than 31.

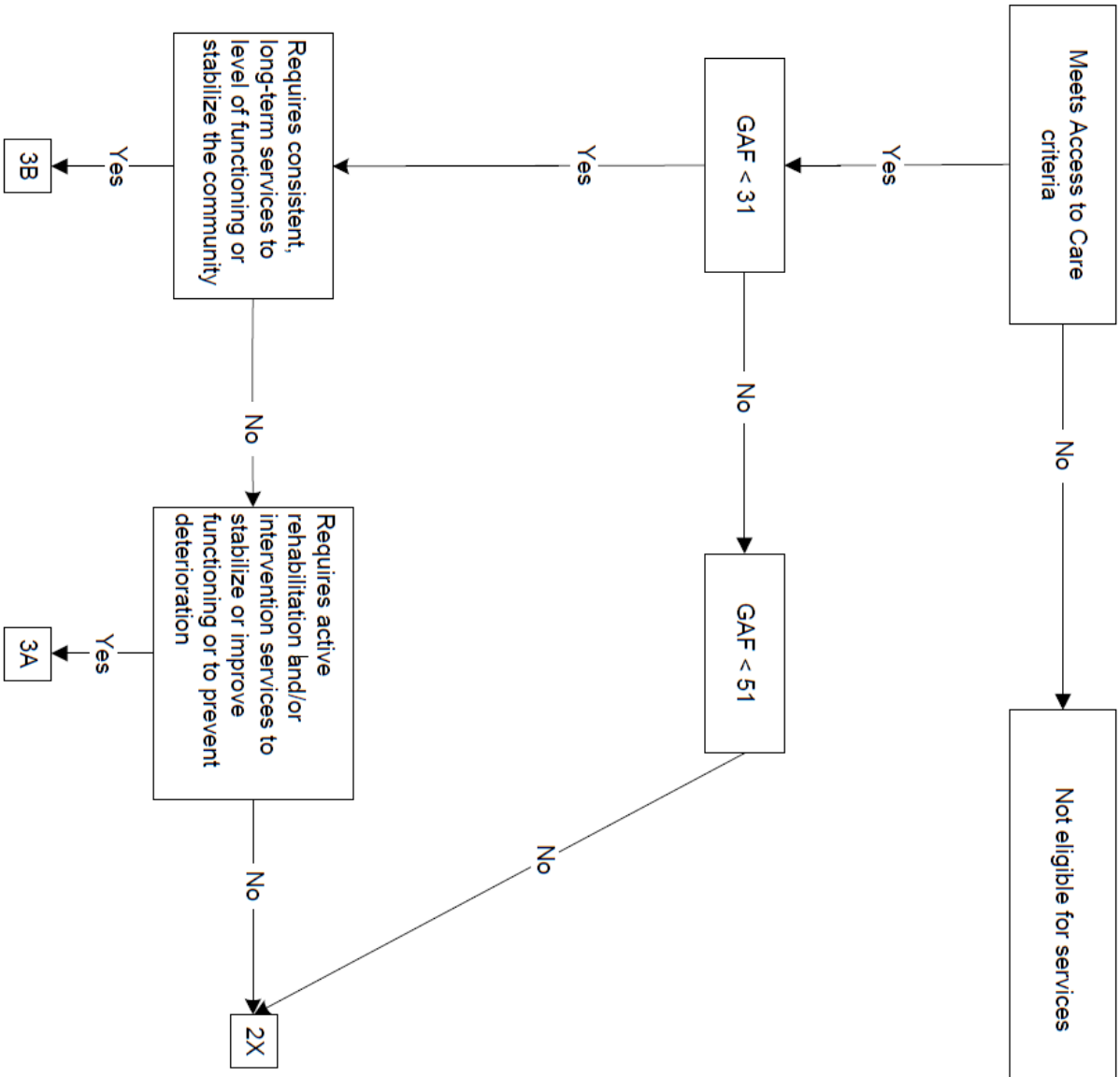
Expected Outcome(s):
1. Improvement/stabilization of psychiatric symptoms.
2. Improvement/stabilization of level of functioning.
3. Prevention of psychiatric hospitalization.
4. Prevention of incarceration.
5. Prevention of homelessness.
6. Linkage with medical system.

Benefit Period: 365 days


Medical Necessity Decision Tree:
Children Younger Than Six Years of Age
Meets Access to Care Criteria
Yes
No
Not eligible for services
Severe Developmental Abnormality. (Shown by one of):
Aggressive or Injurious Behavior
Atypical Emotional Response
Atypical Thinking Patterns
Social Withdrawal
Indiscriminate Sociability
Fearfulness/Distress Which Doesn't Respond To Comfort
Yes
No
Past behavior indicates chronic, high level of danger to self, others, or property; disruption, oppositionality, or conduct difficulties
Yes
No
Requires consistent, intensive, long-term services to improve level of functioning or stabilize in the community
Yes
No
3B
Requires active rehabilitation and/or intervention services to stabilize or improve functioning or to prevent deterioration
Yes
No
3A
2X


Medical Necessity Decision Tree: Children Ages 6 to 18
Meets Access to Care Criteria
Yes
No
Not eligible for services
CGAS < 41
Yes
No
Past behavior indicates chronic, high level of danger to self, others, or property; disruption, oppositionality, or conduct difficulties
Yes
No
Requires consistent, intensive, long-term services to improve level of functioning or stabilize in the community
Yes
No
3B
CGAS < 51
Yes
No
Requires active rehabilitation and/or intervention services to stabilize or improve functioning or to prevent deterioration
Yes
No
3A
2X


Medical Necessity Decision Tree: Children Ages 18 to 21
Meets Access to Care Criteria
Yes
No
Not eligible for services
GAF < 31
Yes
No
Past behavior indicates chronic, high level of danger to self, others, or property; disruption, oppositionality, or conduct difficulties
Yes
No
Requires consistent, intensive, long-term services to improve level of functioning or stabilize in the community
Yes
No
3B
GAF < 51
Yes
No
Requires active rehabilitation and/or intervention services to stabilize or improve functioning or to prevent deterioration
Yes
No
3A
2X


Medical Necessity Decision Tree: Adults and Older Adults
Meets Access to Care criteria
Yes
No
Not eligible for services
GAF < 31
Yes
No
GAF < 51
Yes
No
Requires consistent, long-term services to level of functioning or stabilize the community
Yes
3B
No
Requires active rehabilitation and/or intervention services to stabilize or improve functioning or to prevent deterioration
Yes
3A
No
2X

Assessment Scales

Parent-Infant Relationship Global Assessment Scale (PIR-GAS) (For Children 0 To 5 Years of Age)

This scale is to be used to assess the quality of the child-parent relationship and ranges from well adapted to severely impaired. In general, it is expected that the scale will be completed after a clinical evaluation of a child problem. Relationship problems may co-occur with symptomatic behaviors in the child but are not synonymous with them. This means that serious symptoms may be apparent in a child without relationship pathology, and relationships may be pathological without overt symptoms in the child. The reason for relationship problems need not be known to use the scale, but they may derive from within the child, from within the caregiver, from the unique "fit" between child and caregiver, or from the larger social context. Stressors impinging on the relationship may be etiologically significant, but what is coded is only the pattern of the relationship, not the magnitude of stressor.

90 Well Adapted:

Relationships in this range are functioning exceptionally well. They are not only mutually enjoyable and unusually conflict free, but they are also growth promoting for both partners' development.

80 Adapted:

Relationships in this range of functioning evidence no significant psychopathology. They are characterized by interactions that are frequently reciprocal and synchronous and are reasonably enjoyable. The developmental progress of the partners is not impeded in any way by the pattern of the relationship, which is "good enough" for both partners.

70 Perturbed:

Relationships in this range are functioning less than optimally in some way. The disturbance is limited to one domain of functioning, and overall the relationship still functions reasonably well. The disturbance lasts from a few days to a few weeks.

Example: An infant with a minor physical illness sleeps poorly for several nights, exhausting his parents; or parents moving into a new house are less attentive to their infant, who is less able to self-regulate in the unfamiliar new surroundings.

60 Significantly Perturbed:

Relationships in this range of functioning are strained in some way but are still largely adequate and satisfying to the partners. The disturbance is not pervasive across a large number of domains, but instead, limited to one or two problematic areas. Further, the dyad seems likely to negotiate the challenge successfully and the pattern not to be enduring. The disturbance lasts no longer than a month. Caregivers may be stressed by the perturbation, but they are generally not overly concerned about the changed relationship pattern, instead considering it within the range of expectable responses that are likely to be relatively short-lived.

Example: A toddler develops food refusal for the first time following the birth of a new sibling.

50 Distressed:

Relationships in this range of functioning are more than transiently affected, but they still maintain some flexibility and adaptive qualities. One or both partners may be experiencing some distress in the context of the relationship, and the developmental progress of the dyad seems likely to be impeded if the pattern does not improve. Caregivers may or may not be concerned about the disturbed relationship pattern, but overt symptoms resulting from the disturbance in either partner are unlikely.

Example: A child is distressed frequently when her mother ignores her cues to slow down during feedings and face-to-face interactions. Other domains of functioning show no interaction problems nor child distress.

40 Disturbed:

Relationships in this range of functioning appear to place the dyad at significant risk for dysfunction. The relationship's adaptive qualities are beginning to be overshadowed by problematic features of the relationship. Although not deeply entrenched, the patterns appear more than transient and are beginning to adversely affect the subjective experience of one or both partners.

Example: Parent and child engage in excessive teasing and power struggles in multiple domains including, feeding, dressing, and bedtime. Although parent and child attempt pleasurable interactions, they often go too far, leaving one or both partners distressed.

30 Disordered:

Relationships in this range of functioning are characterized by relatively stable, maladaptive interactions and distress in one or both partners within the context of the relationship. Rigidly maladaptive interactions, particularly if they involve distress in one or both partners, are the hallmark of disordered relationships. Although generally conflicted, interactions in disordered relationships may instead be grossly inappropriate developmentally without overt conflicts.

Example: A depressed parent repeatedly seeks comfort from his or her infant, actively recruiting caregiving behavior from the child.

20 Severely Disordered:

Relationships in this range of functioning are severely compromised. One or more likely both partners are significantly distressed by the relationship itself. Maladaptive interactive patterns are rigidly entrenched, appear to be relatively impervious to change, and seem to be of relatively long duration, although the onset may be insidious. A significant proportion of interactions is almost always conflicted.

Example: A father and his toddler frequently interact in a conflicted manner. The father sets no limits until he becomes enraged and then he spanks the toddler vigorously. The toddler is provocative and the father feels angry with him all the time.

10 Grossly Impaired:

Relationships in this range of functioning are dangerously disorganized. Interactions are disturbed so frequently that the child is in imminent danger of physical harm.

Children's Global Assessment Scale (For Children 6 To 18 Years of Age)

Note: Rate symptoms and dysfunction due to the "Access to Care" eligible diagnosis(es) only.

Rate the subject's most impaired level of general functioning for the specified time period by selecting the lowest level which describes his/her functioning on a hypothetical continuum of health-illness. Use intermediary levels (e.g., 35, 58, 62). Rate actual functioning regardless of the treatment or prognosis. The examples of behavior provided are only illustrative and are not required for a particular rating.

CODE	(**NOTE:** *Use intermediate codes when appropriate, e.g., 45, 68, 72*.**)**
100 | 91	**Superior functioning in all areas (at home, at school and with peers); involved in a wide range of activities and has many interests** *(e.g., has hobbies or participates in extracurricular activities or belongs to an organized group such as Scouts, etc.);* **likable, confident; "everyday" worries never get out of hand; doing well in school; no symptoms.**
90 | 81	**Good functioning in all areas; secure in family, school and with peers; there may be transient difficulties and "everyday" worries that occasionally get out of hand** *(e.g., mild anxiety associated with an important exam; occasionally "blowups" with siblings, parents or peers)*
80 | 71	**No more than slight impairment in functioning at home, at school or with peers; some disturbance of behavior or emotional distress may be present in response to life stresses** *(e.g., parental separations, deaths, birth of sibling)* **but these are brief and interference with functioning is transient; such children are only minimally disturbing to others and are not considered deviant by those who know them.**
70 | 61	**Some difficulty in a single area, but generally functioning pretty well** *(e.g., sporadic or isolated antisocial act, such as occasionally playing hooky or petty theft)* **consistent minor difficulties with school work; mood changes of brief duration; fears and anxieties which do not lead to gross avoidance behavior; self-doubts; has some meaningful interpersonal relationships; most people who do not know the child well would not consider him/her deviant but those who do know him/her well might express concern.**
60 | 51	**Variable functioning with sporadic difficulties or symptoms in several but not all social areas; disturbance would be apparent to those who encounter the child in a dysfunctional setting or time but not to those who see the child in other settings.**
50 | 41	**Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area, such as might result from, for example, suicidal preoccupations and ruminations, school refusal and other forms of anxiety, obsessive rituals, major conversion symptoms, frequent anxiety attacks, poor or inappropriate social skills, frequent episodes of aggressive or other antisocial behavior with some preservation of meaningful social relationships.**
40 | 31	**Major impairment in functioning in several areas and unable to function in one of these areas, is disturbed at home, at school, with peers or in society at large** *(e.g., persistent aggression without clear instigation, markedly withdrawn and isolated behavior due to either mood or thought disturbance, suicidal attempts with clear lethal intent)***; such children are likely to require special schooling and/or hospitalization or withdrawal from school (but this is not sufficient criterion for inclusion in this category).**
30 | 21	**Unable to function in almost all areas (***e.g., stays at home, in ward or in bed all day without taking part in social activities***) OR severe impairment in reality testing OR serious impairment in communication** *(e.g., sometimes incoherent or inappropriate)***.**
20 | 11	**Needs considerable supervision to prevent hurting others or self** *(e.g., frequently violent, repeated suicide attempts)* **OR to maintain personal hygiene, OR gross impairment in all forms of communication (***e.g., severe abnormalities in verbal and gestural communication, marked social aloofness, stupor etc.***)**
10 | 1	**Needs constant supervision (24-hour care) due to severely aggressive or self-destructive behavior OR gross impairment in reality testing, communication, cognition, affect or personal hygiene.**
0	Inadequate information.

Global Assessment of Functioning (GAF) Scale

Note: Rate symptoms and dysfunction due to the "Access to Care" eligible diagnosis(es) only.

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health - illness. Do not include impairment in functioning due to physical or environmental limitations.

CODE	(NOTE: *Use intermediate codes when appropriate, e.g., 45, 68, 72*.)
100 | 91	**Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.**
90 | 81	**Absent or minimal symptoms** *(e.g., mild anxiety before an exam),* **good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns** *(e.g., an occasional argument with family members).*
80 | 71	**If symptoms are present, they are transient and expectable reactions to psychosocial stressors** *(e.g., difficulty concentrating after family argument);* **no more than slight impairment in social, occupational, or school functioning** *(e.g., temporarily falling behind in schoolwork).*
70 | 61	**Some mild symptoms** *(e.g., depressed mood and mild insomnia)* **OR some difficulty in social, occupational or school functioning** *(e.g., occasional truancy or theft within the household)***, but generally functioning pretty well, has some meaningful interpersonal relationships.**
60 | 51	**Moderate** symptoms *(e.g., flat affect and circumstantial speech, occasional panic attacks)* **OR moderate difficulty in social, occupational or school functioning** *(e.g., few friends, conflicts with peers or co-workers).*
50 | 41	**Serious symptoms** *(e.g., suicide ideation, severe obsessional rituals, frequent shoplifting)* **OR any serious impairment in social, occupational or school functioning** *(e.g., no friends, unable to keep a job).*
40 | 31	**Some impairment in reality testing or communication** *(e.g., speech is at times illogical, obscure, or irrelevant)* **OR major impairment in several areas such as work or school, family relations, judgment, thinking or mood** *(e.g., depressed man avoids friends, neglects family and is unable to work; child frequently beats up younger children, is defiant at home and is failing at school).*
30 | 21	**Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment** *(e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation)* **OR inability to function in almost all areas** *(e.g., stays in bed all day; no job, home, or friends).*
20 | 11	**Some danger of hurting self or others** *(e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement)* **OR occasionally fails to maintain minimal personal hygiene** *(e.g., smears feces)* **OR gross impairment in communication** *(e.g., largely incoherent or mute).*
10 | 1	**Persistent danger of severely hurting self or others** *(e.g., recurrent violence)* **OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.**
0	Inadequate information.

CHECKLIST FOR CASE REVIEW
KING COUNTY MENTAL HEALTH PLAN

To assist provider staff in preparing for the case discussion that may be required to complete the 3B case rate and other specialized situations authorization process, the following list of typical questions is provided. KCMHP staff may ask additional questions. The answers to these questions should be based on information documented in the clinical record.

Note: For 3B authorization requests, if the questions below are answered in the materials sent for 3B authorization, KCMHP may not have to call for additional information.

Questions related to level of functioning and problem severity:

- What are the client's current behaviors, functioning and/or symptoms that qualify him/her for the ratings given?

- If there is no immediate evidence but there is a concern that current services must be continued in order to prevent the occurrence of the behavior, functioning and/or symptoms that correlate with the rating, why is that felt to be the case? For example, has the client recently received less intensive services and experienced a deterioration or hospitalization?

Questions related to the proposed Individual Service Plan:

A. Scope, including involvement with other systems

- Are the assessed symptoms and behaviors addressed in the Individual Service Plan (ISP)? If not, why not?

- If both immediate and future interventions are included, do the immediate interventions relate to the future ones? If not, why not?

- If the assessment notes that the client is involved with other systems, does the plan include coordination with these other systems? If not, why not?

B. Intensity/efficiency

- What is the frequency, time, and duration of each proposed intervention?

- Are the services in the plan immediately available, so the plan can begin right away?

- Are all participants in the plan willing to participate (e.g., client, family, other collaterals)? If not, how is this accounted for?

- Can the treatment goals be met with a more streamlined ISP? If not, how is this known?

C. Proposed Interventions

- Describe how the proposed interventions will meet the needs of the client.
- Does the plan correspond with the diagnosis-specific and other treatment guidelines?

Questions related to the previous benefit

- If there are new treatment elements in the proposed plan, why are they being added now? (For example, changes in the client's readiness to participate, availability of new services, availability of staff with different expertise)
- If the previous ISP did not occur as proposed, why not? If the proposed ISP is the same, why is it expected to be successful now?
- If the ISP proposes more intensive services than the client has recently received, what is the evidence supporting the increased intensity and what is the evidence that the client will participate in the new plan?

EXTRAORDINARY TREATMENT PLAN (ETP) REQUEST FORM
KING COUNTY REGIONAL SUPPORT NETWORK/MENTAL HEALTH PLAN

Client Name:_____ **Gender:**_____ **DOB:**_____ **KCID**_____

Provider:_____ **Provider Code:**_____

Address:_____ **Phone Number:** _____

Contact Person:_____ **Current Case Rate:**_____

Total Amount Requested:

_____

This is to document:

☐ Exceptional Need

Time Period (not to exceed 90 days)

From: _____

To: _____

Please attach separate sheets as needed to complete the following:

I. Clinical, Medical and Psychiatric Assessment

Differential diagnosis, medical consultations/testing (conducted or planned), medication management. Explain circumstances warranting special consideration.

II. Proposed Treatment

Include current outpatient authorization service hours provided to date and the individual's comprehensive Individual Service Plan incorporating the interventions, etc. related to the ETP request and the subsequent plan for discontinuing special status. Provide information regarding client's agreement with or willingness to participate in the plan.

III. Financial Plan

Show actual costs and all available funds. Note other potential funding sources and amount.
Identify monthly amount requested by modality and hours to be provided and number of months projected to complete treatment. Include a grid with the following headings: Services to be Provided, Service Period, Requested Funding.

IV. Funding From Allied Systems

Attach letters from allied systems (e.g., Division of Child and Family Services, Home and Community Services, etc.) indicating their participation in funding of the treatment plan or denials of requests for funding from the allied systems.

Signature: **Date:**

_____ _____

Case Manager

I have reviewed the client's chart and discussed this ETP proposal with the staff providing the treatment. I agree that the plan represents recognized standards of care and that every element of the ISP and ETP (modality, amount) is necessary to meet outcomes. I approve the submission of the request to KCMHP.

Signature: **Date:**

Clinical Director
Telephone #: _____

I have discussed this client with the treating prescriber and/or reviewed the file and agree that the documentation supports the diagnosis, medication regimen, and ISP and ETP elements. I approve the submission of the request to KCMHP.

Signature: **Date:**

Medical Director
Telephone #: _____

Fax to MHCADSD 206-205-1634 Attn: Clinical Specialist

For King County Mental Health Plan use only

Reviewed by/ Copy sent to:

☐ KCMHP Clinical Specialist Name:_____

☐ KCMHP Medical Director Name:_____

☐ KCMHP Billing and Reimbursement Name:_____

Disposition: ☐ Approved ☐ Denied ☐ Pended for additional information

State Plan Modalities

Brief Intervention Treatment:

Solution-focused and outcomes-oriented cognitive and behavioral interventions intended to ameliorate symptoms, resolve situational disturbances which are not amenable to resolution in a crisis service model of care and which do not require long-term treatment, to return the individual to previous higher levels of general functioning. Individuals must be able to select and identify a focus for care that is consistent with time-limited, solution-focused, or cognitive-behavioral model of treatment. Functional problems and/or needs identified in the Individual Service Plan must include a specific time frame for completion of each identified goal. This service does not include ongoing care, maintenance/monitoring of the enrollee's current level of functioning and assistance with self/care or life skills training. Enrollees may move from Brief Intervention Treatment to longer term Individual Services at any time during the course of care. This service is provided by or under the supervision of a Mental Health Professional.

Crisis Services:

Evaluation and treatment of mental health crisis to individuals experiencing a crisis. A mental health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, whose outcome decides whether possible bad consequences will follow. Crisis services shall be available on a 24-hour basis. Crisis Services are intended to stabilize the person in crisis, prevent further deterioration, and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. Crisis services may be provided prior to completion of an intake evaluation. Services are provided by or under the supervision of a mental health professional.

Day Support:

An intensive rehabilitative program which provides a range of integrated and varied life skills training (e.g., health, hygiene, nutritional issues, money management, maintaining living arrangement, symptom management) for individuals enrolled in a KCMHP benefit to promote improved functioning or a restoration to a previous higher level of functioning. The program is designed to assist the individual in the acquisition of skills, retention of current functioning or improvement in the current level of functioning, appropriate socialization, and adaptive coping skills. Eligible individuals must demonstrate restricted functioning as evidenced by an inability to provide for their instrumental activities of daily living. This modality may be provided as an adjunctive treatment or as a primary intervention. The staff-to-consumer ratio is no more than 1:20 and is provided by or under the supervision of a mental health professional in a location easily accessible to the client (e.g., community mental health agencies, clubhouses, community centers). This service is available five hours-a-day, five days-a-week.

Family Treatment:

Psychological counseling provided for the direct benefit of an individual enrolled in a KCMHP benefit. Service is provided with family members and/or other relevant persons in attendance as active participants. Treatment shall be appropriate to the culture of the client and their family and should reinforce the family structure, improve communication and awareness, enforce and reintegrate the family structure within the community, and reduce the family crisis/upheaval. The treatment will provide family-centered interventions to identify and address family dynamics and build competencies to strengthen family functioning in relationship to the consumer. Family treatment may take place without the consumer present in the room, but service must be for the benefit of attaining the goals identified for the individual in their individual service plan. This service is provided by or under the supervision of a mental health professional.

Freestanding Evaluation and Treatment:

Services provided in freestanding inpatient residential (non-hospital/non-IMD) facilities licensed by the Department of Health and certified by the Department of Social and Health Services to provide medically necessary evaluation and treatment to individuals who would otherwise meet hospital admission criteria. These are not-for-profit organizations. At a minimum, services include evaluation, stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses and other mental health professionals, and discharge planning involving the individual, family, significant others so as to ensure continuity of mental health care. Nursing care includes, but is not limited to, performing routine blood draws, monitoring vital signs, providing injections, administering medications, and observing behaviors and presentation of symptoms of mental illness. Treatment modalities may include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology. The individual is discharged as soon as a less restrictive plan for treatment can be safely implemented.

This service is provided for individuals who pose an actual or imminent danger to self, others, or property due to a mental illness, or who have experienced a marked decline in their ability to care for self due to the onset or exacerbation of a psychiatric disorder.

The severity of symptoms, intensity of treatment needs or lack of necessary supports for the individual does not allow them to be managed at a lesser level of care.

This service does not include cost for room and board.

The Mental Health Division must authorize exceptions for involuntary length of stay beyond a 14-day commitment.

Group Treatment Services:

Services provided to individuals enrolled in a KCMHP benefit designed to assist in the attainment of goals described in the Individual Service Plan. Goals of Group Treatment may include developing self care and/or life skills, enhancing interpersonal skills, mitigating the symptoms of mental illness, and lessening the results of traumatic experiences, learning from the perspective and experiences of others and counseling/psychotherapy to establish and /or maintain stability in living, work, or educational environment. Individuals eligible for Group Treatment must demonstrate an ability to benefit from experiences shared by others, demonstrate the ability to participate in a group dynamic process in a manner that is respectful of other's right to confidential treatment and must be able to integrate feedback from other group members. This service is provided by or under the supervision of a mental health professional to two or more Medicaid enrolled individuals at the same time. Staff to consumer ratio is no more than 1:12. Maximum group size is 24.

High Intensity Treatment:

Intensive levels of service otherwise furnished under this state plan amendment that is provided to individuals who require a multi-disciplinary treatment team in the community that is available upon demand based on the individual’s need. Twenty-four hours-a-day access is required if necessary, seven days-a-week. Goals for High Intensity Treatment include the reinforcement of safety, the promotion of stability and independence of the individual in the community, and the restoration to a higher level of functioning. These services are designed to rehabilitate individuals who are experiencing severe symptoms in the community and thereby avoid more restrictive levels of care such as psychiatric inpatient hospitalization or residential placement.

The team consists of the individual, Mental Health Care Providers, under the supervision of a mental health professional, and other relevant persons as determined by the individual (e.g., family, guardian, friends, neighbors). Other community agency members may include probation/parole officers*, teacher, minister, physician, chemical dependency counselor*, etc. Team members work together to provide intensive coordinated

High Intensity Treatment: (cont'd)

and integrated treatment as described in the individual service plan.

The team's intensity varies among individuals and for each individual across time. The assessment of symptoms and functioning will be continuously addressed by the team based on the needs of the individual allowing for the prompt assessment for needed modifications to the individual service plan or crisis plan. Team members provide immediate feedback to the individual and to other team members. The staff to consumer ratio for this service is no more than 1:15.

Billable components of this modality include time spent by the mental health professionals, mental health care providers and peer counselors.

Although they participate, these team members are paid staff of other Departments and therefore not reimbursed under this modality.

Individual Treatment Services:

A set of treatment services designed to help individuals enrolled in a KCMHP benefit attain goals as prescribed in their individual treatment plan. These services shall be congruent with the age, strengths, and cultural framework of the individual and shall be conducted with the individual, his or her family, or others at the individual's behest who play a direct role in assisting the individual to establish and/or maintain stability in his/her daily life. These services may include, developing the individual's self-care/life skills; monitoring the individual's functioning; counseling and psychotherapy. Services shall be offered at the location preferred by the Medicaid-enrolled individual. This service is provided by or under the supervision of a mental health professional.

Intake Evaluation:

An evaluation that is culturally and age relevant initiated prior to the provision of any other mental health services, except crisis services, services, stabilization services, and free-standing evaluation and treatment. The intake evaluation must be initiated within 10 working days of the request for services, establish the medical necessity for treatment and be completed within 30 working days. Routine services may begin before the completion of the intake once medical necessity is established. This service is provided by a mental health professional.

Medication Management:

The prescribing and/or administering and reviewing of medications and their side effects. This service shall be rendered face-to-face by a person licensed to perform such services. This service may be provided in consultation with collateral and primary therapists and/or case managers, but includes only minimal psychotherapy.

Medication Monitoring:

Face-to-face one-on-one cueing, observing, and encouraging an individual to take medications as prescribed. Also includes reporting back to persons licensed to perform medication management services for the direct benefit of the Medicaid enrolled individual. This activity may take place at any location and for as long as it is clinically necessary. This service is designed to facilitate medication compliance and positive outcomes. Enrollees with low medication compliance history or persons newly on medication are most likely to receive this service. This service is provided by or under the supervision of a mental health professional. Time spent with the enrollee is the only direct service billable component of this modality.

Mental Health Clubhouse (B3 waiver):

A service specifically contracted by the RSN/PIHP to provide a consumer-directed program to persons enrolled in a KCMHP benefit enrollees where they receive multiple services. These services may be in the form of support groups, related meetings, consumer training, peer support, etc. Consumers may drop in on a daily basis and participate, as they are able. Clubhouses must use the International Center for Clubhouse Development (ICCS) standards as guidelines. Services include the following:

- Opportunities to work within the clubhouse, such work contributing to the operation and enhancement of the clubhouse community;
- Opportunities to participate in administration, public relations, advocacy and evaluation of clubhouse effectiveness;
- Assistance with employment opportunities, housing, transportation, education and benefits planning;
- Operate at least 10 hours-a-week after 5:30 p.m., Monday through Friday, or anytime on Saturday or Sunday; and
- Opportunities for socialization activities.

Mental Health Clubhouses are not an alternative for day support services.

Mental Health Services provided in Residential Settings:

A specialized form of rehabilitation service (non-hospital/non-IMD) that offers a sub-acute psychiatric management environment. Individuals receiving this service present with severe impairment in psychosocial functioning, or have apparent mental illness symptoms with an unclear etiology due to their mental illness and treatment cannot be safely provided in a less restrictive environment, and they do not meet hospital admission criteria. Individuals in this service require a different level of service than High Intensity Treatment. The Mental Health Care Provider is sited at the residential location (e.g., boarding homes, supported housing, cluster housing, SRO apartments) for extended hours to provide direct mental health care to a Medicaid enrollee.

Therapeutic interventions both in individual and group format may include medication management and monitoring, stabilization, and cognitive and behavioral interventions designed with the intent to stabilize the individual and return him/her to more independent and less restrictive treatment. The treatment is not for the purpose of providing custodial care or respite for the family, nor is it for the sole purpose of increasing social activity or used as a substitute for other community-based resources. This service is billable on a daily rate. In order to bill the daily rate for associated costs for these services, a minimum of eight hours of service must be provided. This service does not include the costs for room and board, custodial care, and medical services, and differs for other services in the terms of location and duration.

Peer Support:

Services provided by peer counselors to individuals enrolled in a KCMHP benefit, under the consultation, facilitation or supervision of a mental health professional who understands rehabilitation and recovery. This service provides scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Consumers actively participate in decision-making and the operation of the programmatic supports.

Self-help support groups, telephone support lines, drop-in centers, and sharing the peer counselor's own life experiences related to mental illness will build alliances that enhance the consumer's ability to function in the community. These services may occur at locations where consumers are known to gather (e.g., churches, parks, community centers, etc). Drop-in centers are required to maintain a log documenting identification of the consumer including Medicaid eligibility.

Services provided by peer counselors to the consumer are noted in the consumers' Individual Service Plan which delineates specific goals that are flexible tailored to the consumer and attempt to utilize community and

Peer Support: (cont'd)

natural supports. Monthly progress notes document consumer progress relative to goals identified in the Individual Service Plan, and indicate where treatment goals have not yet been achieved.

Peer counselors are responsible for the implementation of peer support services. Peer counselors may serve on High Intensity Treatment Teams.

Peer support is available daily no more than four hours per day. The ratio for this service is no more than 1:20.

Psychological Assessment:

All psychometric services provided for evaluating, diagnostic, or therapeutic purposes by or under the supervision of a licensed psychologist. Psychological assessments shall: be culturally relevant; provide information relevant to a consumer's continuation in appropriate treatment; and assist in treatment planning within a licensed mental health agency.

Rehabilitation Case Management:

A range of activities by the outpatient community mental health agency's liaison conducted in or with a facility for the direct benefit of an individual in the public mental health system. To be eligible, the individual must be in need of case management in order to ensure timely and appropriate treatment and care coordination.

Activities include assessment for discharge or admission community to mental health care, integrated mental health treatment planning, resource identification and linkage to mental health rehabilitative services, and collaborative development of individualized services that promote continuity of mental health care. These specialized mental health coordination activities are intended to promote discharge, to maximize the benefits of the placement, and to minimize the risk of unplanned readmission and to increase the community tenure for the individual. Services are provided by or under the supervision of a mental health professional.

Respite Care (B3 waiver):

A service to sustain the primary caregivers of children with serious or emotional disorders or adults with mental illness. This is accomplished by providing observation, direct support and monitoring to meet the physical, emotional, social and mental health needs of an individual consumer by someone other than the primary care givers. Respite care should be provided in a manner that provides necessary relief to caregivers. Respite may be provided on a planned or an emergent basis and may be provided in a variety of settings such as the consumer or caregiver's home, in an organization's facilities, in the respite worker's home etc. The care should be flexible to ensure that the individual's daily routine is maintained. Respite is provided by, or under the supervision of, a mental health professional. Respite under this waiver is only available to those consumers who do not have this coverage under some other federal program.

Special Population Evaluation:

Evaluation by a child, geriatric, disabled, or ethnic minority specialist that considers age and cultural variables specific to the individual being evaluated and other culturally and age competent evaluation methods. This evaluation shall provide information relevant to a consumer's continuation in appropriate treatment and assist in treatment planning. This evaluation occurs after intake. Consultation from a non-staff specialist (employed by another CMHA or contracted by the CMHA) may also be obtained, if needed, subsequent to this evaluation and shall be considered an integral, billable component of this service.

Stabilization Services:

Services provided to individuals who are experiencing a mental health crisis. These services are to be provided in the person's own home, or another home-like setting, or a setting which provides safety for the individual and the mental health professional. Stabilization services shall include short-term (less than two weeks per episode) face-to-face assistance with life skills training, and understanding of medication effects. This service includes: a) follow-up to crisis services; and b) other individuals determined by a mental health professional to need additional stabilization services. Stabilization services may be provided prior to an intake evaluation for mental health services.

Supported Employment (B3 waiver):

A service for Individuals enrolled in a KCMHP benefit who are currently neither receiving nor who are on a waiting list to receive federally funded vocational services such as those provided through the Department of Vocational Rehabilitation. Services will include:

- An assessment of work history, skills, training, education, and personal career goals.
- Information about how employment will affect income and benefits the consumer is receiving because of his/her disability.
- Preparation skills such as resume development and interview skills.
- Involvement with consumers served in creating and revising individualized job and career development plans that include:
    - Consumer strengths;
    - Consumer abilities;
    - Consumer preferences; and
    - Consumer's desired outcomes.
- Assistance in locating employment opportunities that is consistent with the consumer's strengths, abilities, preferences, and desired outcomes.
- Integrated supported employment, including outreach/job coaching and support in a normalized or integrated work site, if required.

Services are provided by or under the supervision of a mental health professional.

Therapeutic Psychoeducation:

Informational and experiential services designed to aid individuals enrolled in a KCMHP benefit, their family members (e.g., spouse, parents, siblings), and other individuals identified by the individual as a primary natural support, in the management of psychiatric conditions, increased knowledge of mental illnesses and understanding the importance of their individual plan of care. These services are exclusively for the benefit of the enrolled individual and are included in the Individual Service Plan.

The primary goal is to restore lost functioning and promote reintegration and recovery through knowledge of one's disease, the symptoms, precautions related to decompensation, understanding of the "triggers" of crisis, crisis planning, community resources, successful interrelations, medication action and interaction, etc. Training and shared information may include brain chemistry and functioning, latest research on mental illness causes and treatments, diagnostics, medication education and management, symptom management, behavior management, stress management, crisis management, improving daily living skills, independent living skills, problem-solving skills, etc.

Services are provided at locations convenient to the consumer, by or under the supervision of a mental health professional. Classroom-style teaching, family treatment, and individual treatment are not billable components of this service.

Co-Occurring Disorder Screening and Assessment

1. KCMHP, providers, and CCS shall maintain the implementation of the integrated, comprehensive screening and assessment process for substance use and mental disorders as required by Chapter 70.96C Revised Code of Washington (RCW).

2. An attempt shall be made to screen all individuals aged 13 and above through the use of the DSHS-provided Global Appraisal of Individual Needs – Short Screener (GAIN-SS) during:

    a. All new intakes including intakes for individuals whose prior authorization has been expired for at least 90 days and who have not completed a GAIN-SS screening within the previous 12 months.
    b. The provision of each crisis episode of care including ITA investigations services, except when:
        i. The service results in a referral for an intake assessment;
        ii. The service results in an involuntary detention under Chapters 71.05, 71.34 or 70.96B RCW;
        iii. The contact is by telephone only; or
        iv. The professional conducting the crisis intervention or ITA investigation has information that the individual completed a GAIN-SS screening within the previous 12 months.
    c. The six months following an individual's 13th birthday for youth who began receiving services prior to becoming age 13.

3. The GAIN-SS screening must be completed as self-report by the individual and signed by that individual on the DSHS-GAIN-SS form. If the individual refuses to complete the GAIN-SS screening or if the clinician determines the individual is unable to complete the screening for any reason, this must be documented on the DSHS-GAIN-SS form.

4. The results of the GAIN-SS screening, including refusals and anywhere the individual was unable to complete, must be reported to KCMHP through MHCADSD IS.

5. A co-occurring mental health and substance use disorder assessment must be completed, consistent with training provided by the DSHS and outlined in the SAMHSA Treatment Protocol 42, to determine a quadrant placement for the individual when the individual scores a 2 or higher on either of the first two scales (ID Screen and ED Screen) and a 2 or higher on the third (SD Screen).

    a. The assessment is required during the next outpatient treatment planning review following the screening and as part of the initial evaluation at free-standing, non-hospital, evaluation and treatment facilities. The assessment is not required during crisis interventions or ITA investigations.
    b. The quadrant placements are defined as:
        i. Less severe mental health disorder/less severe substance use disorder;
        ii. More severe mental health disorder/less severe substance use disorder;
        iii. Less severe mental health disorder/more severe substance use disorder; or
        iv. More severe mental health disorder/more severe substance use disorder.

6. The quadrant placement must be reported to the KCMHP through the MHCADSD IS.

CRISIS PLAN

Agency Name:

Client Name:_____DOB_____

PLAN DATE: _____ REVIEW/UPDATE: _____ REVIEW/UPDATE: _____ REVIEW/UPDATE: _____
Reason for Plan: ___ 3B; ___ At least one hospitalization, incarceration/detention in past 12 months; ___ Substance use disorder; ___ Suicide (risk or history); ___ Violence (risk or history; ___ Multiple system involvement (youth); ___ Used ER in past 12 months; ___ Has an advance directive; ___ Other (document) ___Client at risk ____ Residential Services

CLIENT INFORMATION

Gender: _____ Benefit: _____ Benefit end date: ___/___/___

Race/Ethnicity:_____

Primary Language: _____
Interpreter needed: ____ Yes ____ No

Client phone #: _____

AGENCY INFORMATION

Day Phone: (_____)_____

After-Hours Phone: (_____)_____

Case Mgr. _____
Phone: (_____)_____

Type of residence: ____ Facility ____ Independent ____ Foster Care ____ Group Care (Youth)

Residence Address: _____ City _____ State _____ Zip _____

Living with (name): _____ Relationship: _____

Emergency Contact/Next of Kin: _____ Phone: (_____)_____
(Include guardians, Durable Power of Attorney)

PSYCHIATRIC HISTORY

Diagnoses: 1. _____ 2. _____ 3. _____
(Include substance use and personality disorders)
Current Psych. Meds: _____
_____
_____ As of (date): ____/____/____

Prescriber of psych. Meds: ____Enrolling Agency _____Other prescriber. If other, name: _____
Telephone number: (_____)_____

Hospitalizations	Hospital	Dates (admission to d.c.)	Vol or Invol
	1._____	_____	_____
(List Past 3)	2._____	_____	_____
	3._____	_____	_____

Current Less Restrictive Order? _____ Start Date: _____ End Date: _____
(Order must be available 24 hours a day)

MEDICAL HISTORY

Medical Problems (include allergies):

_____

_____

Medications: _____

_____As of (date): ____/____/____

Primary Care MD/ARNP/PA: _____ Phone: _____

History of violence (threats/attempts, incl. sex offense/deviancy, weapons, and dates)	**History of suicide/self harm** (threats/attempts and dates)	**Substance Use** (describe type, frequency)
_____ _____	_____ _____	_____ _____

Criminal Behavior/Jail History (describe behavior and date):

_____

_____

_____

Baseline Behavior/Mental Status: _____

_____

_____

Other Relevant Information (employment, DOC, DCFS/school contact person if a child, treatment compliance):

_____

_____

_____

Characterize Decompensation (include early and late signs): _____

_____

_____

Effective Interventions – (*what would another clinician need to know?)* should address cultural, sexual orientation, age, or other special population considerations (include client quotes, natural supports, input from support system where possible and appropriate):

_____

_____

Client Perceptions
Early warning signs for me include:

_____

_____

What helps me to recover includes:

_____

_____

Advance Directive on File? _____ Yes _____ No (If yes, must be available 24 hours a day)

Who participated in developing this plan (check all that applies): __ client __ case manager __ family __ other supports.

If client did not participate, why not? _____

Signature of Person Completing Crisis Plan:	**Signature of Client (if appropriate):**
_____	_____
(Print name) _____	
Program: _____	Date: ____/____/____

Mental Health Information on an Inmate Currently in Outpatient Care

Attention: Jail Health Psychiatric Staff

Confidential fax: 206-296-0299

Phone: 206-296-1770

Client name (write all information large and legibly): _____

Client DOB: _____

Diagnosis: _____

_____

Current psychiatric medications: _____

_____

_____

_____

Client's pharmacy phone/fax numbers: _____

Recent medication compliance (check one):

- ☐ Good recent medication compliance
- ☐ Poor medication compliance over the last week
- ☐ Don't know, but usually good compliance
- ☐ Don't know, but usually poorly compliant
- ☐ Don't know

Optional additional information:
Active physical health problems_____

Medications for non-psychiatric problems_____

Allergies _____

Current risk factors for suicide or violence_____

Active substance use, including tobacco use (specify)

Other _____

Case manager:

Date:

Best number for jail to call for additional information:

Conditions/Circumstances Impacting Behavior *

Conditions:

1. Medical Condition Affecting Psychological Functioning (Axis III)
2. Neurological Condition Affecting Psychological Functioning (Axis III)
3. Fetal Alcohol Spectrum Disorder or Fetal Drug Exposure (Axis III)
4. Developmental Disorder (Suspected or Identified) (Axis III)
5. Learning Disability (per Educational Assessment)
6. Seriously Behaviorally Disturbed (per Educational Assessment)
7. Substance Use in Child
8. Law Breaking Behavior in Child (either Adjudicated or by History)
9. Attachment Difficulties (derived from before age 5)
10. Multiple Systems Involvement
11. Receiving Special Education Services
12. None of the conditions apply to this client

Circumstances:

1. Family Discord
2. Out-of-Home Placement
3. Inadequate Parenting/Child Neglect
4. Physical Abuse
5. Sexual Abuse
6. Domestic Violence
7. Child Witness to Violence or Traumatic Death
8. Death of Parent
9. Troubled Sibling
10. Suicidal Behavior in a Parent
11. Divorce/Separation of Parents
12. Health Problems in Parents
13. Substance Use in Parents
14. Parents Involvement in Criminal Justice System
15. Mental Illness in Parents
16. Cognitive Impairment in Parents
17. Child's Parent(s) Teens
18. Teen Parenthood or Pregnancy
19. Harassment or Abuse by Peers
20. Cultural or Sexual Minority Status Where Context Creates Risk
21. Multiple Moves
22. Homelessness, Children

***** Derived from Washington State guidelines for EPSDT, modified to meet the needs of the King County Prepaid Health Plan. See also Section XII, Information Systems, "Provider Transactions," Attachment B.

Determining King RSN Eligibility for People who Live in Zip Codes that Overlap Counties

For persons who live in zip code areas that overlap between counties, providers must take the steps below to determine if someone is eligible for King RSN benefits. People who are in crisis in King County are eligible for crisis and involuntary treatment act services regardless of residency.

1. All Individuals (Medicaid and non-Medicaid).
   a. If the person lives in one of the zip codes in the following table, his or her address must be confirmed to be within the boundaries of King County to be eligible for King RSN services.
   b. Persons whose address is in Snohomish or Pierce counties should be directed to request services through North Sound or Pierce RSNs.

Zip	City	RSN could be either…			For Medicaid, ProviderOne shows…
98020	Edmonds	King	Or	North Sound	North Sound
98021	Bothell	King	Or	North Sound	North Sound
98022	Enumclaw	King	Or	Pierce	King
98023	Federal Way	King	Or	Pierce	King
98047	Pacific	King	Or	Pierce	King
98072	Woodinville	King	Or	North Sound	King
98077	Woodinville	King	Or	North Sound	King
98092	Auburn	King	Or	Pierce	King
98251	Gold Bar	King	Or	North Sound	North Sound
98354	Milton	King	Or	Pierce	Pierce

2. Medicaid Individuals.
   a. For apparently Medicaid eligible individuals, the person's Medicaid and RSN service eligibility must be verified through ProviderOne as illustrated in the sample ProviderOne Managed Care Information table below.

Managed Care Information

Insurance Type Code ▲ ▼	PCCM Code ▲ ▼	Plan/PCCM Name ▲ ▼	Plan/PCCM ID ▲ ▼	Plan/PCCM Phone Number ▲ ▼	PCP Clinic Name ▲ ▼	Start Date ▲ ▼	End Date ▲▽
HM: Health Maintenance Organization	MC: Capitated						
HM: Health Maintenance Organization	MC: Capitated	King County Regional Support Network	Xxxxxx	(800) 790-8049		06/01/2010	12/31/2999

   b. The ProviderOne system is designed to make capitated payments to RSNs based on zip code regardless of the county in which the person actually resides, so it is possible for a person to be a resident of King County and be listed in ProviderOne as belonging to Pierce RSN or North Sound RSN and vice versa.

   c. The MHCADSD IS will automatically identify an individual as King RSN eligible if: (1) The agency reports that the client lives in King County; (2) The client's zip code is in the list above; and (3) ProviderOne shows RSN eligible coverage for any RSN.

VII. RESIDENTIAL AND SUPPORTIVE HOUSING SERVICES LEVEL OF CARE

1.0 POLICY TITLE: RESIDENTIAL AND SUPPORTIVE HOUSING SERVICES LEVEL OF CARE

1.1 Originally Implemented: April 1, 1995

1.2 Reviewed and revised: November 2014

1.3 Officially Adopted: January 2, 2015

1.4 Effective Date: February 2, 2015

1.5 Signed: _____
Jean Robertson, Assistant Division Director/RSN Administrator

2.0 PURPOSE: To describe the residential and supportive housing services level of care within the King County Mental Health Plan (KCMHP). The goal of this level of care is to help clients move to more independent settings and less intensive services. Residential and supportive housing services are described in decreasing intensity below.

2.1 Residential Services

2.1.1 Long-term rehabilitative (LTR) services are licensed, facility-based services that provide on-site mental health treatment to clients who require a highly structured environment that has a continuous intensive staff presence. LTR participants receive room and board, residential stabilization services, daily support services, on-site psychiatric evaluation, medication management, and case management for both housing and mental health needs.

2.1.2 Supervised Living (SL) services are less intensive licensed, facility-based services for clients who also require the structure of a therapeutic environment that has 24-hour staffing but do not require the level of intervention provided at an LTR. Individuals receive room and board, residential stabilization services, and daily support services. SL participants receive mental health services through a concurrent outpatient benefit.

2.2 Supportive Housing Services

2.2.1 Standard Supportive Housing (SSH) services are for clients who may require regular staff contact and the availability of staff 24 hours a day, seven days a week, but who do not need the physical safety and structure of a residential facility. Clients may be housed in cluster or independent settings.

3.0 POLICY/PROCEDURES/RESPONSIBILITIES FOR ACCESS TO SERVICES:

3.1 Financial eligibility

3.1.1 Eligibility for services is the same as that for the outpatient services level of care, for both Medicaid and non-Medicaid persons.

3.1.2 The residential and supportive housing services level of care is available only to clients who are 18 years of age or older. Residential services for some children are available through the state Department of Child and Family Services.

3.2 Medical necessity

3.2.1 Persons authorized to the residential and supportive housing services level of care are expected to move to more independent service types as their level of clinical need decreases. To be eligible for this level of care, clients must meet two sets of criteria:

A. The Access to Care criteria, described in the medical necessity criteria for the outpatient services level of care, and

B. The specific criteria for placement in:

1. Long-term rehabilitative (LTR) residential services (Attachment B);

2. Supervised living (SL) residential services (Attachment C);

3. Standard supportive housing (SSH) services.

3.2.2 Clients meeting these criteria will have demonstrated need for intensive services for a significant period of time to stabilize psychiatrically and in their housing.

3.3 Authorization for residential and supportive housing services

3.3.1 For individuals who are currently in inpatient care, the authorization process is preceded by screening of referred individuals by the adult inpatient and residential liaisons.

3.3.2 For individuals who are currently in outpatient or specialty services the screening and referral process will be completed by the outpatient provider.

A. Providers shall assess for the following eligibility criteria:

1. Current Medicaid eligibility.

2. Individuals who have been admitted to psychiatric inpatient (voluntary or involuntary services and/or jail two or more times within the prior year.

3. The individual's impairment must demonstrate moderate to serious functional impairment in multiple areas with a Global Assessment of Functioning (GAF) score of **no more than 41.**

4. The individual's needs cannot be more appropriately met by any other formal or informal system or support.

B. Providers shall complete the following referral information and submit to the KCMHP Clinical Specialist:

1. Residential and Supportive Housing Services Placement Request (Attachment E)
2. Residential Services Screening Form (Attachment A)
3. Most recent psychiatric assessment
4. Current treatment plan
5. Last 60 days of progress notes
6. Most recent hospital discharge summary

C. The referral packet will be reviewed and a residential level of care determined within 7 days of receipt of the referral.

D. If approved, the client's name will be added to the residential bed list.

E. KCMHP will notify the local residential liaison and the referring provider of the decision.

F. The residential level of care determination will be valid for 90 days.

3.3.3 Under no circumstances shall a person be placed in the KCMHP residential and supportive housing services level of care without prior approval by a liaison or other KCMHP designated staff. Residential services will not be reimbursed by KCMHP without this documented pre-approval.

3.3.4 Liaisons will screen and place eligible clients according to the following two priority groups:

A. First priority group:

1. Clients at Western State Hospital/Program for Adaptive Living Skills (PALS);
2. Clients admitted to inpatient psychiatric units or evaluation and treatment facilities;
3. Clients who are currently residing in one of the following types of residential facilities:
    a. An LTR facility; or
    b. An SL facility;
4. Clients who are currently receiving one of the following intensive services:
    a. Expanded Community Services (ECS);
    b. Program for Assertive Community Treatment (PACT); or

c. Forensic Assertive Community Treatment (FACT); and

B. Second priority group:

1. Eligible clients who are currently incarcerated in a local jail;

2. Clients who are not currently hospitalized or in jail but who have two or more psychiatric inpatient and/or jail stays within the previous two years, or a psychiatric inpatient stay of more than 30 days in the previous two years; or

3. Clients who are at risk of hospitalization and need a higher level of services over time to remain stable in the community.

3.3.5 For residential (SL/LTR) and supportive housing (SSH) screenings, the liaisons will:

A. Obtain clinical information from all relevant sources, including the MHCADSD Information System (IS);

B. Interview the client and his/her appropriate support network;

C. Review:

1. The completed Residential and Supportive Housing Services Placement Request form (Attachment E); or

2. In the circumstances noted in 3.3.5.A below, the SSH Transition Form (Attachment I) instead, along with the associated clinical packet;

D. Except in circumstances noted in 3.3.5.A and 3.3.5.C below, complete:

1. The Residential Services Screening Form (Attachment A); or

2. For placement of second-priority clients into SSH, the SSH Transition Form (Attachment I) instead, including securing the required clinical packet from the relevant provider(s);

E. Ensure that the criteria in Attachments B, C, or D, whichever is appropriate to the client, have been met;

F. Identify financial resources and submit findings to the provider;

G. For placement of second-priority clients into SSH, or for clients transitioning from SSH to LTR or SL when they have been in SSH less than 90 days, submit for King County MHCADSD review and approval:

1. Form(s) required according to sections C and D above; and

2. The associated clinical packet;

H. Facilitate the client interview at the residential or housing site;

I. For clients being screened for SL services, ensure that the client has an intake appointment scheduled for the outpatient services level of care;

J. For LTR and SL, send the signed Regional Support Network (RSN), Residential Services Placement Request form (Attachment E) to the residential staff within two working days; and

K. Assist with the client's move, along with the referent, the residential provider staff, and (for SL) the outpatient provider.

3.3.6 For certain SSH, SL, and LTR screenings, neither new/updated Residential Services Placement Requests (Attachment E) nor Residential Services Screening Forms (Attachment A) are required. Instead:

A. The process in section B below applies when clients are:

1. Transitioning from LTR or SL with one provider to SSH with a different provider;

2. Transitioning from SSH to LTR or SL when they have been in SSH less than 90 days; or

3. Transferring from one SSH provider to another SSH provider;

B. In the circumstances in section A above:

1. The referent will complete and submit to the liaison the SSH Transition Form (Attachment I) and an associated clinical packet in lieu of the Residential Services Placement Request (Attachment E); and

2. The liaison will not be required to complete a new/updated Residential Services Screening Form (Attachment A); and

C. When clients are transitioning from LTR or SL to SSH without changing providers:

1. The referent will complete the SSH Transition Form (Attachment I) and place it directly in the clinical chart, in lieu of the Residential Services Placement Request (Attachment E). The clinical packet is not required; and

2. The referent will not be required to send documentation to the liaison for review, but the referent will inform the liaison of the client's transition into SSH.

3.3.7 In cases requiring Clinical Services review, King County MHCADSD will provide written certification of approval to the liaison to document authorization for placement.

3.3.8 Authorization following the screening

A. Duration of authorized benefit:

1. For LTR and SL, an authorization has no expiration date; and

2. For and SSH, an authorization is for one year of service.

B. Authorization requests for LTR, SL, and first- and second-year SSH benefits are processed electronically with authorization approvals sent to the requesting provider immediately on receipt of complete and properly submitted information. Should the provider submit information that is incomplete or improperly submitted regarding a Medicaid client who meets medical necessity criteria, the provider shall initiate medically necessary services immediately while the data submission problems are corrected.

C. Authorization requests for services proceed as follows:

1. After the liaison completes steps A through H outlined in section 3.3.4, the provider submits to KCMHP Clinical Services the following information:

a. A diagnosis that meets the Access to Care criteria;

b. A Global Assessment of Functioning score of 30 or below; and

c. An individual service plan (ISP) that demonstrates service intensity appropriate to; and

2. If the diagnosis and ISP requirements are met, KCMHP Clinical Services will authorize the benefit and update the MHCADSD IS.

3.4 Continuing stay criteria

3.4.1 For SL and LTR services, as the authorization has no expiration date, the authorization continues until such time as the client no longer meets the medical-necessity criteria for the placement and appropriate alternative housing and services have been arranged.

A. The KCMHP will conduct or will request the SL and LTR provider to conduct periodic reviews of clients enrolled in LTR and SL residential services in order to ensure that clients continue to need their benefit.

3.4.2 For Standard Supportive Housing (SSH) services

A. At the 18-month ISP review, the multi-disciplinary team assesses whether the client will be able to graduate from the SSH program at 24 months.

B. If a continuation of an SSH benefit will be requested at 24 months, the SSH provider must submit to King County MHCADSD Clinical Services for review:

1. Level of Care Utilization System (LOCUS) justification for each domain, with a narrative summary; and

2. An up-to-date ISP.

   a. The ISP will identify needs and barriers that must be addressed in order to enable the client to transition to an outpatient level of care benefit.

   b. Each barrier will be addressed separately in the ISP with a goal and a strategy.

C. Clinical services may request that the provider participate in a clinical care conference for the identified client.

D. If an SSH benefit will not be requested at 24 months, then no documentation needs to be sent to Clinical Services at the 18-month review.

E. If at any time after the 18-month review, the SSH provider determines that a client who was previously scheduled to graduate will need a continued SSH benefit beyond 24 months, the SSH provider will send the required documents (listed in section B above) as soon as this determination is made.

F. For a client authorized to receive a continuation of an SSH benefit, an updated ISP is completed for the newly authorized benefit. The ISP may be requested for review by Clinical Services.

G. If the provider seeks further extensions based on the client's need for SSH services, this review and reauthorization process is repeated every 12 months until the client transitions out of SSH.

3.5 Termination and discharge

3.5.1 A provider must submit to the MHCADSD IS a request to terminate a benefit under the following circumstances:

A. The client no longer meets the medical-necessity criteria for the residential and supportive housing services level of care and appropriate alternative housing and services have been arranged;

B. For LTR and SL, the client leaves the facility for longer than five days (by choice, due to hospitalization or incarceration, or due to unplanned discharge) and the liaison determines that the placement should not be held for the client's return;

C. The client dies;

D. The client moves out of the County;

E. The client is enrolled in Program for All-Inclusive Care of the Elderly (PACE); or

F. The client gains enough resources during the benefit to be treated as a private-pay client.

3.5.2 A terminated benefit is payable to the date of termination.

A. For the required terminations above, the date of the termination is the date of the event, unless otherwise specified.

B. When a required termination is not submitted or is submitted with an incorrect effective date, payment for the benefit beyond the correct effective date may be recouped.

3.5.3 If a benefit is being terminated because a client is transferring to a new provider, the original provider must continue to provide services for the client until it receives an electronic notification of the termination of the benefit. The original provider shall not initiate termination of the benefit.

3.5.4 If a client leaves an LTR or SL placement (either planned or unplanned) for more than five working days, the following applies:

A. Residential staff must notify the KCMHP Clinical Specialist or designee and indicate the total number of days the client will be absent and the reason for the absence;

1. If absence is planned, notification should occur prior to leave; or

2. If absence is unplanned, notification should occur no later than day 6.

3. Staff should complete and submit Residential Absence Authorization form (Attachment J).

B. The Clinical Specialist or designee will review the case and determine if the LTR/SL bed should remain open for the client and if so, approve an extension for payment for the bed days. The Specialist will fax a copy of the approved absence authorization to the KCMHP contract monitor and the agency within 3 business days;

C. All planned leaves must be consistent with the client's ISP;

D. For clients residing in an LTR facility, at all times that the client is not present, the residential staff is responsible for providing for ongoing case management for that client, including crisis intervention and stabilization, until the client has returned to the residential bed; and

E. If the client will not be returning to:

1. An LTR facility, the LTR staff is responsible for linking the client to appropriate services; or

2. An SL facility, the outpatient staff is responsible for linking the client to appropriate services.

3.5.5 When a client leaves SSH services, the provider will similarly assist the client in accessing appropriate services.

3.5.6 If the client is ending services due to no longer needing KCMHP services at any level, this type of termination is called a discharge.

3.6 Client notice and appeals

3.6.1 See Section III: Client Rights for the definition of an Action and for the requirement that a Notice of Action be sent to a Medicaid client whenever an adverse Action occurs.

3.6.2 The following events are Actions for the residential and supportive housing services level of care when they occur regarding a Medicaid client:

A. Services are denied;

B. An authorization is terminated; or

C. A reduction or suspension of services previously authorized for a Medicaid client.

3.6.3 The following events are not Actions:

A. The assignment of a particular residential facility or other residential benefit, either by a provider or KCMHP;

B. The moving of a client from one type of residential or supportive housing benefit to another: SL to LTR, SL to supportive housing, etc.; or

C. The failure to authorize a request due to a provider failure to provide adequate information.

3.6.4 A change from the residential and supportive housing level of care to non-residential outpatient services only is considered a reduction of the previously authorized residential service, unless it occurs at the time of expiration of a supportive housing benefit.

3.6.5 See Section III: Client Rights regarding the recipients of the Notice, the content of the Notice, and the time frames for sending a Notice.

3.6.6 Also, see Section III: Client Rights section regarding rights related to appeals, state fair hearings, and the continuation of services during an appeal, grievance, or state fair hearing process.

3.6.7 Procedure for sending notices

A. The residential provider shall enter data into King County MHCADSD IS indicating that the client is leaving the residential level of care by moving from an LTR. Receipt of the data will trigger KCMHP to send a Notice of Action.

B. In all other instances, KCMHP staff will send the Notice of Action without requiring an alert from providers.

3.7 Provider appeals

Providers may appeal an authorization decision using the same process described for the outpatient level of care in Section VI: Outpatient Services Level of Care.

4.0 POLICY/PROCEDURES/RESPONSIBILITIES FOR SERVICES:

4.1 Services

4.1.1 Services shall be provided according to all of the following values:

A. Cultural, linguistic and disability competent;

B. Orientated towards promoting recovery and resiliency;

C. Appropriate to the age and developmental stage of the client; and

D. Preference for the most independent living setting.

4.1.2 Long-term rehabilitative (LTR) residential services are licensed, facility-based services that provide on-site mental health treatment to clients who require a highly structured environment that has a continuous intensive staff presence.

A. LTR providers will have the capacity to provide clients with all necessary modalities available to clients in the outpatient level of care.

B. LTR services are transitional. It is expected that LTR services will help clients develop the skills necessary to enable them to transition to less intensive residential care or community-based housing.

4.1.3 Supervised living (SL) residential services are licensed, facility-based services that provide on-site mental health services to clients who require the structure of a therapeutic environment that has 24-hour, seven days-a-week staffing but is less intensive than an LTR.

A. A client must be authorized simultaneously to an outpatient benefit to be eligible for SL.

B. SL providers will have the capacity to provide on-site interventions designed to supplement the outpatient ISP in the areas of self-care skills, medication self-management, and preparation for a client's transition to community-based housing.

C. SL services are transitional. It is expected that most clients will move to community-based housing within two years.

D. If a client experiences a crisis while in SL services but off-site, the outpatient service provider will be responsible for the crisis services. If the client is on-site, the SL provider will be responsible for basic in-residence crisis stabilization. The outpatient service provider will be responsible for back-up on-site crisis services, if requested by the SL provider.

4.1.4 Standard supportive housing (SSH) services are for clients who may require daily staff contact and the availability of staff 24 hours a day, 7 days a week, but who do not need the physical safety and structure of a residential facility.

A. Services are provided through multidisciplinary teams. These teams will have the capacity to provide (or refer) clients with all necessary modalities available to clients in Section VI: Outpatient Services Level of Care.

B. Clients in SSH are not simultaneously authorized to an outpatient benefit.

C. Clients in SSH usually require less on-site services and have fewer medical/health issues requiring staff monitoring.

D. SSH services are transitional. Length of stay will be determined by the process outlined in section 3.4.3 above.

4.1.5 Individual Service Plan (ISP)

A. Each client in the residential and supportive housing level of care shall have an ISP that meets the requirements of Chapter 246-325 Washington Administrative Code (WAC) and WAC 388-865-0235(4) and 0425, or their successors, and the Outpatient Level of Care ISP requirements in Section VI.

B. The ISP must:

1. Be developed within 30 days of the start of placement;

2. Be reviewed and updated at the180th day from start of placement and every 180 days thereafter, or more often if indicated or requested by the client; and

3. Include a discharge plan that identifies:

a. The barriers that prevent a client from moving to a more normative placement or level of care that supports optimal functioning;

b. The strategies to remove those barriers, if possible; and

c. The anticipated timelines and conditions to be met for this to occur.

C. For clients receiving LTR, or SSH services, the provider will be responsible for the development and implementation of the ISP.

1. The ISP must address the area(s) from the Residential Services Screening form (Attachment A) that were used to justify the need for LTR or SSH services.

D. For clients receiving SL services, the SL provider and the outpatient services provider will develop the ISP in consultation with one another and with client participation.

1. The ISP will be signed by the SL provider, the outpatient service provider, and the client.

2. A copy of the ISP will be maintained at the SL facility and in the outpatient services clinical record.

3. The ISP must address the area(s) from the Residential Services Screening form (Attachment A) that were used to justify the need for SL residential services.

4.1.6 Crisis Plan

A. Each client shall have an up-to-date crisis plan according to the requirements for clients in the outpatient services level of care.

B. For clients receiving LTR or SSH services, the provider will be responsible for the crisis services plan.

C. For clients receiving SL services, the outpatient provider will be responsible for the crisis plan.

1. The plan must be developed in consultation with the SL provider.

2. A copy of the current crisis plan shall be maintained at both the SL residential facility and in the outpatient clinical record.

4.2 Documentation requirements

All residential and supportive housing services should be documented in the client's clinical record.

5.0 INFORMATION SYSTEMS BUSINESS RULES:

5.1 The provider shall ensure that all data stored on the MHCADSD IS describing the client and any services received under the case rate are complete and accurate.

5.2 Authorization

Data status and timelines

5.2.1 Authorization to the residential and supportive housing level of care occurs entirely electronically in most cases. Requests must be submitted in accordance with the "Authorization Request" transaction (Section XII: Information Management, Attachment B).

5.2.2 When an authorization request electronically submitted by a provider is successfully processed, the authorization is assigned an authorization number and data status. For Supportive Housing Program authorizations (SSH) and LTR authorizations, data status is updated as needed when additional data are added.

See data status descriptions in Information Systems Business rules in Section VI: Outpatient Services Level of Care.

5.2.3 Data posting timelines

A. MHCADSD IS is responsible for ensuring that data are posted to the master event tables no later than 7 p.m. on the day following the day of the provider data submission.

B. The dates of posting submitted data to the master tables are the dates used to determine data timeline compliance and data status.

5.3 Authorization process

5.3.1 The initial authorization data must be submitted within 10 working days of the client's admission to residential services.

5.3.2 All authorization requests are processed within 24 hours of MHCADSD IS receipt of the request.

5.3.3 For SSH authorizations when a provider has submitted adequate data for a PY status, the data are tested to ensure that the client has a covered diagnosis, has a qualifying GAF/CGAS score, and meets coverage requirements.

5.3.4 For SSH authorizations, eligibility and medical necessity are tested and if necessary recalculated by MHCADSD IS and processed on a daily basis.

5.3.5 For non-routine situations, KCMHP clinical team may also create a retroactive authorization, posting an authorization record without an existing authorization request.

5.4 Authorization Status Codes

5.4.1 At any one time, an authorization request will have one of the following status codes:

UA	Unauthorized • Authorization request meets technical requirements and authorization number has been assigned. • However, there is inadequate information to complete the authorization.
AA	Authorization Approved • Authorization is approved for a residential benefit and payment begins for Supportive Housing authorizations.

CX	Cancelled • Authorization is canceled. • Any payments made are recouped.
TM	Terminated • Authorization has been terminated. • For Supportive Housing Program authorizations only payments made after the termination date are recouped.

5.4.2 Providers receive daily reports whenever a change in the authorization status code for a request has occurred.

5.4.3 When an authorization request cannot be processed, the provider will be notified via daily error reports.

5.5 Continuing Stay

For provider request to renew an existing SSH authorization:

5.5.1 The assessment date of the request must be within the last 30 days of the current authorization;

5.5.2 The posting date of the continuation request must be on or before the cutoff date of the next authorization request;

5.5.3 The start date of the new authorization will be set to the day following the expiration date of the current authorization;

5.5.4 A request for a next benefit must refer to a valid authorization that has not been canceled or terminated; and

5.5.5 All other aspects of requesting a continued authorization are the same as requesting an initial authorization.

5.6 Terminations

5.6.1 Provider Request for Termination

A. The posting date must be no more than 60 days after the expiration date of the existing authorization.

B. The existing authorization must not already be canceled or terminated.

C. The authorization does not have a pending manual review.

5.6.2 Supportive Housing authorizations that are terminated are paid until the date of termination.

5.7 Cancellations

Provider Requests for Cancellation

5.7.1 For provider requests to cancel an existing authorization request due to a submission error

A. The posting date must be on or before the authorization change cutoff date.

B. The existing authorization request must not already have a cancellation status.

C. LTR authorizations can only be canceled by MHCADSD.

5.7.2 Supportive Housing authorizations that are cancelled are subject to recoupment.

6.0 FINANCIAL BUSINESS RULES:

6.1 Daily rates

6.1.1 Providers are paid for the delivery of residential services according to a daily rate.

6.1.2 Each residential or supportive housing benefit will be defined as LTR, SL, or SSH determining the payment rate.

6.1.3 Providers are prepaid monthly.

A. For services to clients with ongoing benefits, providers receive the amount for that client at the start of the month for services to be provided during that month.

B. For services to new clients or to clients ending services, adjustments to payment may be applied retroactively.

C. Additional adjustments may occur as needed.

6.2 For facility-based residential services, the residential provider will also submit to the MHCADSD IS the start date and exit date from the Residential Facility Transaction in Section XII: Information Systems, Attachment A. These dates will be used to generate the residential services payment.

6.2.1 The start date is the date the client moves into the facility.

6.2.2 The start date may not be prior to the certification date signed by the liaison.

6.2.3 The exit date is the last date the client is in the residential bed at 11:59 p.m.

6.2.4 When a client leaves a residential placement:

A. After the liaison has been notified, the residential staff will close both the residential authorization and the facility stay in the MHCADSD IS; and

B. The residential staff is responsible for ensuring that the required exit data is submitted to the MHCADSD IS as described in Section XII: Information Systems, Attachment A.

6.2.5 The exit date must be submitted to the MHCADSD IS no later than two weeks after the actual exit date.

6.3 Client participation

Residential providers shall submit to KCMHP a report that summarizes the client participation and the additional allocation for those persons on Supplemental Security Income.

6.4 Payment of subcontractors

If a provider chooses to have a credentialed subcontractor provide services to an authorized client, it is the responsibility of the provider and subcontractor to negotiate payment for services.

7.0 LIST OF ATTACHMENTS:

7.1 Attachment A: Residential Services Screening Form

7.2 Attachment B: Long-Term Rehabilitation Placement Criteria

7.3 Attachment C: Supervised Living Placement Criteria

7.4 Attachment D: Standard Supportive Housing Placement Criteria

7.5 Attachment E: Residential Services Placement Request Form

7.6 Attachment F: Residential Annual Review Form

7.7 Attachment G: SL and LTR Continued Stay Criteria

7.8 Attachment H: Residential Services Tracking

7.9 Attachment I: SSH Transition Form

7.10 Attachment J: Residential Absence Authorization Form

8.0 REFERENCES:

Washington State Law, Regulations, and Policy including any successor, amended, or replacement laws**,** regulations**,** or policies

- Chapters 388-865, 388-877, and 388-877A WAC – Department of Social and Health Services – Mental Health – Community Mental Health and Involuntary Treatment Programs

- Chapter 246-325 WAC – Department of Social and Health Services – Adult Residential Rehabilitation Centers and Private Adult Treatment Homes

- Chapter 71.24 Revised Code of Washington – Mental Illness – Community Mental Health Services Act

- Chapter 388-78A WAC – Department of Social and Health Services – Boarding Homes

RESIDENTIAL SERVICES SCREENING FORM
KING COUNTY REGIONAL SUPPORT NETWORK/MENTAL HEALTH PLAN

Client Name:	DOB:	SSN:
Liaison:		Date:

Please complete the sections using both historical and current information to indicate the client's ability to function in the community at this time, without additional community supports.

I. SELF-CARE: Ability to perform daily toileting, grooming, hygiene and eating.

Toileting: _____

Bathing: _____

Grooming: _____

Eating: _____

Other: _____

___1. Client required occasional prompting or no assistance needed.	___2. Client needs regular prompting to perform one or more of the self-care areas: hygiene, toileting or eating.	___3. Client needs persistent monitoring or limited assistance to perform hygiene, toileting, eating.	___4. Client does not respond to intensive prompting. Hands on assistance required. Neglect of self-care is a health hazard.

II. COMMUNITY LIVING: Ability to perform household chores and manage in the community.

Household Chores: _____

Cooking: _____

Laundry: _____

Managing Money: _____

Using Transportation: _____

Keeping Appointments: _____

Other: _____

Victimization: *(Please explain those behaviors that are of concern)*

_____

_____

___1. May need some prompting or no assistance to perform shopping, cleaning, laundry and chores. Assistance can be provided by community support services.	___2. Client is unable to perform chores, cooking, cleaning or shopping. Unable to avoid household dangers or maintain basic safety. At risk for victimization in community at large. Requires structure and supervision.	___3. Unable to use public transportation or attend appointments or treatment programs in the community. Unable to avoid common dangers and victimization in community. Requires supervision and structure as well as on-site treatment.	___4. Requires constant monitoring and supervision to maintain safety.

III. PSYCHIATRIC MEDICATION ISSUES: Please explain client's ability to take prescribed medications consistently and voluntarily. Include client's history of medication compliance and insight into need for medication.

___1. Client complies with prescribed psychiatric medications with occasional prompting or no assistance. Assistance can be provided by community support services.	___2. Client regularly fails to comply with prescribed psychiatric medications without regular notification of medication times and/or verbal prompting to take medications.	___3. Client consistently fails to comply and/or is highly resistant to comply with prescribed psychiatric medications. Typically meds must be monitored or at times directly administered.	___4. Despite consistent prompting client refuses prescribed psychiatric medications.

IV. INTERPERSONAL: Please describe client's non-dangerous behavior that is annoying, interferes with others, or disrupts social interaction, such as teasing, talking in a loud voice, ignoring personal space, stealing or other intrusive behaviors.

Please describe the person's behaviors that indicate he/she avoids or actively withdraws from social interaction.

___1. Client's interpersonal skills may be problematic but can be addressed by community support services.	___2. While the client does not actively avoid social interaction or communication, he/she may not initiate contact with others without assistance or regular prompting. Client's behavior may interfere with social functioning or with the activities of others but can be managed in the milieu. Requires structure and supervision.	___3. Client avoids or withdraws from contact with others, does not engage in social activities or fails to communicate with understandable speech and gestures when approached by another person. Client's behavior severely interferes with social functioning or with the activities of others and needs frequent redirection to manage in milieu setting. Requires structure and supervision as well as on-site treatment.	___4. Client's behavior severity and persistently interferes with social functioning and the activities of others.

V. DANGEROUS/AGGRESSIVE BEHAVIORS: Please describe past or present behaviors which are aggressive, threatening or dangerous to self or others including self-harm, suicide attempts, assault, sexual assault, rape, child molestation, harassment, stalking or fire setting.

___1. Client's behavior may be problematic but can be addressed by community support services.	___2. Client is not currently displaying dangerous behavior. Client may have had 1 or more episodes of dangerous/ aggressive behavior. Typically the client seeks staff assistance when escalating and responds positively to staff redirection.	___3. Client may exhibit dangerous/aggressive behavior but responds positively to staff initiated intervention. Client may have had 1 or more episodes of dangerous behavior.	___4. Client may have had 1 or more episodes of dangerous behavior. Client is not cooperative with interventions and his/her behavior is so severe that he/she poses a significant danger to self or others.

VI. SUSTAINED ATTENTION: Please describe any limitations the client has in the areas of attention span, confusion, disorganization, disorientation and memory and how they interfere with the client's ability to perform daily tasks/activities.

___1. Cognitive impairment is not an issue for this client or can be addressed by community support services.	___2. Cognitive impairment is present and debilitating. Client requires regular prompting by staff or supervision.	___3. Cognitive impairment is persistent and debilitating. Client requires persistent monitoring or limited assistance.	___4. Cognitive impairment is severely debilitating. Client requires constant staff monitoring. Cannot be managed in community setting.

VII. MOOD SYMPTOMS: Please describe mood symptoms such as depression, mania, anxiety or obsessive/compulsive behaviors and how these symptoms interfere with daily functioning.

___1. Client may not exhibit mood symptoms or they can be addressed by community support services.	___2. Signs of mood disturbance are present and may be persistent or debilitating. Client requires regular staff assistance.	___3. Signs of mood disturbance are persistent and debilitating. Client requires intensive staff assistance.	___4. Signs of mood disturbances are debilitating. Client requires constant staff monitoring. Severity of symptoms cannot be managed in community residential setting.

VIII. PSYCHOTIC SYMPTOMS: Please describe symptoms such as hallucinations, delusions or peculiar behavior that the client experiences and how these symptoms interfere with daily functioning. Include relevant historical data.

___1. Client may not exhibit symptoms or they can be addressed by community support services.	___2. Signs of psychotic symptoms are present and may be persistent or debilitating. Client requires regular staff assistance.	___3. Signs of psychotic symptoms are persistent and debilitating. Client requires intensive staff assistance.	___4. Signs of psychotic symptoms are debilitating. Client requires constant staff monitoring. Severity of symptoms cannot be managed in community residential setting.

IX. ADDITIONAL INFORMATION

A. SUBSTANCE USE

Does the client have substance use issues, including tobacco, currently? ☐YES ☐ NO ☐ UNKNOWN

Historically? ☐YES ☐ NO ☐ UNKNOWN

If yes, please describe how the client's substance use impacts his/her psychological, social or occupational functioning. Give historical information when appropriate.

B. PHYSICAL/MEDICAL INFORMATION

Does the client have any significant medical problems, sensory impairment, or physical disabilities?

☐YES ☐ NO ☐ UNKNOWN List problems and assistance needed:

Allergies? ☐ YES ☐ NO ☐ UNKNOWN

Special diet needs ordered by a physician? ☐ YES ☐ NO ☐ UNKNOWN

Incontinence? ☐ YES ☐ NO ☐ UNKNOWN If YES, please describe the frequency and to what degree the client is able to manage the problem on his/her own.

Non-ambulatory? ☐ YES ☐ NO ☐ UNKNOWN Please describe what assistance is required.

C. SHELTER/HOUSING

Has there been a pattern of housing instability? ☐ YES ☐ NO ☐ UNKNOWN

Previous housing situations did not meet client's needs because (check all that apply):

___ Did not like group home living, following rules, privacy issues.

___ Level of support not adequate.

___ Non-compliance with: ___ medications ___ substance use ___ rules

___ Other (Please Specify): _____

RESOURCES NEEDED FOR PLACEMENT

Does the client have special treatment issues or cultural needs that should be addressed to facilitate placement?
☐YES ☐ NO ☐ UNKNOWN Please specify.

Please describe any additional resources needed for placement:

HOSPITALIZATION RISK FACTORS

___ Two (2) or more psychiatric hospitalizations in last 2 years. Please specify dates/locations:

_____
_____
_____
_____

___ Hospital stay exceeding 30 days in the last 2 years. Please specify dates/locations:

_____
_____
_____
_____

___ Currently hospitalized. Please list reasons:

_____
_____
_____
_____

___ At risk for hospitalization. Please specify reasons:

_____
_____
_____
_____

___ Currently homeless ___ At risk for homelessness ___ Unstable living situation

___ None of these apply

SOURCES USED TO COMPLETE THIS FORM

___ Chart review
___ Discussion with treatment team
___ Interview with client
___ Placement Request form
___ Discussion with case manager
___ Discussion with family members
___ Other (please specify):

LEVEL OF CARE RECOMMENDATION

☐ **DEFERRAL DECISION**

___ Client's level of functioning is adequate. Client does not require residential placement.

___ High risk for physically harming others or self. Significant history or likelihood of damage to property, fire setting and/or sexual acting out.

___ Residential treatment is not indicated to address behavior or treatment issues.

___ Has high severity of cognitive functioning impairment that requires more nursing care or a secured setting.

___ Substance use issues make client inappropriate for residential placement.

___ Medical issues and/or ambulating cannot be managed in a community residential setting.

☐ **APPROVAL** **DATE:** _____

Approved for (circle one): SL LTR Intensive Supported Housing

Residential treatment site: _____

Projected move-in date: _____ _____

Estimated length of stay:_____

SUMMARY OF LEVEL OF CARE RECOMMENDATIONS/CONDITIONS OF PLACEMENT:

_____
_____
_____
_____
_____
_____

_____

LIAISON'S SIGNATURE Telephone Number

Long-Term Rehabilitation (LTR) Residential Treatment Services Placement Criteria

Purpose:
To define the criteria for placement for long-term rehabilitation (LTR) residential treatment services.

Eligible Population:
Adults who, due to psychiatric symptoms and behaviors, require extended intensive and comprehensive treatment and 24-hour supervision in a residential treatment setting.

Criteria:
Specific authorization to this level of care is required. Reauthorization is based on progress made on the Individual Service Plan and on the status of criteria 1 and 2 below. To be authorized for LTR services the client must:

1. Have a covered diagnosis as listed in the state Department of Social and Health Services' Access to Care Standards. See Section VI, Outpatient Services, Attachment A for a list of covered diagnoses; **and**

2. At a minimum, have a score of 3 on one of "self care," "community living skills," "interpersonal" or "medication compliance"; **and** a score of 3 or greater on one of "sustained attention/cognitive," "mood symptoms," "psychiatric symptoms" or "assaultive/aggressive" on the "King County Residential Services Screening Form."

Expected Outcomes:

1. Improvement/stabilization of psychiatric symptoms.

2. Improvement/stabilization in level of functioning.

3. Discharge to a less restrictive treatment setting, as clinically indicated.

Supervised Living (SL) Residential Treatment Services Placement Criteria

Purpose:
To define the criteria for placement for supervised living (SL) level residential treatment services.

Eligible Population:
Adults who, due to psychiatric symptoms and behavior, require assistance with self-care skills and/or psychiatric symptom management in a supervised residential setting.

Criteria:
Specific authorization to this level of care is required. Reauthorization is based on progress made on the Individual Service Plan and on the status of criteria 1, 2, and 3 below. To be authorized for SL services the client must:

1. Have a covered diagnosis as listed in the state Department of Social and Health Services' Access to Care criteria (see Section VI, Outpatient Services Level of Care, Attachment A for a list of covered diagnoses); **and**

2. At a minimum, have a score of 2 on one of "self care," "community living skills," "interpersonal" or "medication compliance" **and** a score of 2 or greater on one of "sustained attention/cognitive," "mood symptoms," "psychiatric symptoms," or "assaultive/aggressive," on the "King County Residential Services Screening Form"; **and**

3. Be authorized to the outpatient level of care and receiving services appropriate to the specific outpatient benefit.

Expected Outcomes:
1. Improvement/stabilization of psychiatric symptoms;

2. Improvement/stabilization in level of functioning;

3. Increased participation in community-based activities; and

4. Transition to a more independent housing arrangement, as clinically indicated.

Standard Supportive Housing Residential Treatment Services Placement Criteria

Purpose:
To define the criteria for placement for standard supportive housing residential treatment services.

Eligible Population:
Adults who, due to psychiatric symptoms and behavior, require high intensity treatment as defined in section VI attachment K including 24-hour staff availability, but who do not require 24-hour staff supervision.

Criteria:
To be authorized for standard supported housing services the client must:

1. Have a covered diagnosis as listed in the state Department of Social and Health Services' Access to Care criteria. See Section VI, Outpatient Services Level of Care, Attachment A for a list of covered diagnoses; **and**

2. Have demonstrated history reflecting significant difficulty maintaining tenure in the community. Specifically, clients appropriate for this service will require frequent assistance to manage symptoms and medications, care for themselves, interact with others appropriately, and/or meet the obligations of tenancy.

Expected Outcomes:
1. Improvement/stabilization of psychiatric symptoms;

2. Improvement/stabilization in level of functioning;

3. Increased participation in community-based activities; and

4. Transition to a more independent housing arrangement, as clinically indicated.

Residential and Supportive Housing Services Placement Request
King County Regional Support Network Mental Health Plan

DIRECTIONS:
Client's mental health case manager/staff to complete in full (providing specifics when indicated) for client referral for mental health residential treatment services.

Client Information

Name:

KCID: DOB: Age: Male / Female

SSN: Ethnicity:

Income / SSI Amount: SSA Amount: Disability Lifeline Amount: GAX Amount: Other

Active Coupons? No / Yes CSO Location Type? ☐ Disability Lifeline ☐ GAX ☐ CNP ☐ QMB ☐ Other

KCMHP Agency: Case Rate Benefit: Benefit Expiration Date:

MH Case Manager: Legal Hold? ☐No ☐ Yes Specify: ☐ LR ☐ MR ☐ Jail ☐ Probation

Client's Current Location: HMC: ☐5WA ☐ 5WB ☐ 5WC ☐ Navos ☐ WSH ☐ PCN ☐ JAIL ☐ HOMELESS ☐ COMM.

Specify If Elsewhere:

Payee? ☐No ☐ Yes Name / Agency / Address / Phone:

Guardianship / Trust? ☐ No ☐ Yes Name / Agency / Address / Phone:

Rationale for Placement Request

Describe relevant events from the past 30-90 days as well as related interventions provided/attempted.

Client Diagnostic Profile

Axis I:

Axis II:

Axis III: (list all medical problems)

Primary diagnosis may be one of following:

☐Dev. Disability ☐Dementia ☐Organic (Head Injury) ☐Organic (Drug/Alc) ☐N/A ☐Unk

Medication Information

All current psychiatric and medical medications (dosage & frequency):

How are Rx taken? Injection Liquid Crushed Pills

Is client currently Rx compliant? ☐No ☐Yes Historically Rx compliant? ☐No ☐Yes

Specify difficulties: _____

Any Rx changes in past 30 days? ☐No ☐Yes ☐Unk

Specify: _____

Any Rx changes planned in next 30 days? ☐No ☐Yes ☐Unk

Medication Information (continued)

Any medical problems requiring medical monitoring or nursing care? ☐No ☐Yes ☐Unk
Specify:

Does client require blood draws? ☐No ☐Yes ☐Unk

Any refusals in past 30 days? ☐No ☐Yes ☐Unk

Any history of refusing? ☐No ☐Yes ☐Unk

Does the client take prn's for agitation or anxiety? ☐No ☐Yes ☐Unk

How many PRNs in the last 30 days?

Any benzodiazepine dependency or Rx seeking issues? ☐No ☐Yes ☐Unk

Specify:

Self-Care Skills

Is ambulation an issue for this client? ☐No ☐Yes ☐Unk

Specify:

Are self-care / adult living skills an issue for this client? ☐No ☐Yes ☐Unk
Specify:

Is this person incontinent? No / Yes / Unk If yes, please specify of what? Urinary Bowel Both

Can client manage this on his or her own? No / Yes / Unk

Specify:

Dangerous / Aggressive Behaviors

Does this person have a history of arson or firesetting behaviors? (Including reckless/intentional behaviors that result in fire)
No / Yes / Unk Specify:

Does this person have a history of sexually aggressive behaviors? (Unwanted verbal or written communication, unwanted touching)
No / Yes / Unk Specify:

Does this person have a history of predatory behaviors? (Rape, child molestation, stalking)
No / Yes / Unk Specify:

Does this person have a history of aggressive / assaultive behaviors?
No / Yes / Unk Specify:

Does this person have a legal history?
No / Yes / Unk Specify:

Does this person have a history of self-harm or self-mutilating behaviors?
No / Yes / Unk Specify:

Does this person have a history of suicide attempts?
No / Yes / Unk Specify:

Does this person have difficulty avoiding victimization in the community?
No / Yes / Unk Specify:

Where & when, and for what reasons has this person been hospitalized in the last 2 years?

Dangerous / Aggressive Behaviors (continued)

Specify this person's psychiatric symptoms and behaviors when decompensated:

Substance Use

During the last 90 days, this person has used: Alcohol Drugs (including tobacco) Neither Unk
Specify frequency of use:

During the last 12 months, this person has used: Alcohol Drugs (including tobacco) Neither Unk
Specify frequency of use:

During his/her lifetime? Alcohol Drugs (including tobacco) Neither Unk
Specify frequency of use:

Signs / symptoms of use (circle all that apply):
Daily Use Mood Swings/Changes Attempts To Stop Legal Issues (DWI, etc.)
Blackouts Tremors Binging Memory Loss Dts / Sweats

Has this person ever received substance use disorder treatment? No / Yes / Unk Specify below:

Dates Treated	Where / Type (In-Pt. / Out-Pt.)	Outcome?

Housing

Please list client's housing over last 5 years, **beginning with most recent**. Use additional paper if needed.

Location	Type (e.g. SL, APT)	Dates	Reason For Leaving? (Specify)

Placement Request

Is this person at baseline functioning? No / Yes / Unk Specify:

What placement are you requesting? Residential Treatment (SL/LTR) Supportive Housing (SSH) Other

What placement does family/client support? Residential Treatment (SL/LTR) Supportive Housing (SSH) Other

Client location preference: Urban/City Location Suburban Location Specific City/Area preferred (if any):

Client setting preference (for SSH only): Independent Setting Group/Cluster Setting

Specify how this person would benefit from the requested service:

This information is accurate to the best of my knowledge. I assure that the minimum requirements for authorization residential treatment services have been met.

Name/Title Phone Date

Signature

King County Mental Health, Chemical Abuse and Dependency Services Division
Residential Annual Review[1]

KCID: _____

Site: _____

Circle the category (e.g., minimal, mild, moderate) in each area (e.g., Functional Status, Medical and Addiction Co-Morbidity) that **most closely** fits the person's usual status. The statements below each category heading are general descriptors for that category. The person does not have to meet every criterion in a category - the category chosen should be the one that is the best fit.

Functional Status

The degree to which a person is able to fulfill social responsibilities, to interact with others, maintain his/her vegetative status as well as his/her capacity for self care

Minimal Impairment — **1**

- No more than transient impairment in functioning following exposure to an identifiable stressor

Mild Impairment — **2**

- Some deterioration in interpersonal interactions, with increased incidence of arguments, hostility or conflict, but is able to maintain some meaningful and satisfying relationships
- Recent minor disruptions in aspects of self-care or usual activities
- Developing minor but consistent difficulties in social role functioning and meeting obligations, but maintaining ability to continue in those roles
- Demonstrating significant improvement in function following a period of deterioration

Moderate Impairment (3 points) — **3**

- Becoming conflicted, withdrawn, alienated or otherwise troubled in most significant relationships, but maintains control of any impulsive or abusive behaviors
- Appearance and hygiene may fall below usual standards on a frequent basis
- Significant disturbances in vegetative activities, but these do not pose a serious threat to health
- Significant deterioration in ability to fulfill responsibilities and obligations and these may be avoided or neglected on some occasions
- Chronic and/or variably severe deficits in interpersonal relationships, ability to engage in socially constructive activities, and ability to maintain responsibilities
- Recent gains and/or stabilization in function achieved while participating in treatment in a structured and/or protected setting

[1] Reformatted version of the Level of Care Utilization System for Psychiatric and Addiction Services, Adult Version 2000, American Association of Community Psychiatrists, May 2000.

Serious Impairment • Serious deterioration of interpersonal interactions with consistently conflictual or otherwise disrupted relations with others, which may include impulsive, or abusive behaviors • Significant withdrawal and avoidance of almost all social interaction • Consistent failure to maintain personal hygiene, appearance, and self care near usual standards • Serious disturbances in vegetative status that threatens physical well being • Inability to perform close to usual standards for role obligations and these responsibilities may be completely neglected on a frequent basis or for an extended period of time	**4**
Severe Impairment • Extreme deterioration in social interactions which may include chaotic communication, threatening behaviors with little or no provocation, or minimal control of impulsive or abusive behavior • Development of complete withdrawal from all social interactions • Complete neglect of personal hygiene and appearance and inability to attend to most basic needs • Extreme disruptions in vegetative function causing serious harm to health and well being • Complete inability to maintain any aspect of personal responsibility as a citizen, or in job, educational, or parental roles	**5**

Medical and Addiction Co-Morbidity

Potential complications related to co-existing medical illness and/or substance use disorders in addition to the presenting disorder

No Co-Morbidity • No evidence of medical illness, substance use disorders, or psychiatric disturbances apart from the presenting disorder • Any illnesses that may have occurred in the past are now stable and pose no threat to the stability of the current condition	**1**
Minor Co-Morbidity • Existence of medical problems that are not themselves immediately threatening or debilitating and that have no impact on the course of the presenting disorder • Occasional episodes of substance misuse, but episodes are self limited and show no pattern of escalation	**2**

Significant Co-Morbidity • Medical conditions exist that may require significant medical monitoring • Ongoing or episodic substance use occurring despite adverse consequences • Recent substance use that has had clearly detrimental effects but that has been temporarily arrested through the use of a highly structured or protected setting, or through other external means	**3**
Major Co-Morbidity • Medical conditions exist, or have a very high likelihood of developing, that may require intensive, although not constant, medical monitoring • Uncontrolled substance use occurs at a level that poses a serious threat to health if unabated	**4**
Severe Co-Morbidity • Significant medical conditions exist that may be poorly controlled and/or potentially life threatening in the absence of close medical management • Severe substance dependence with inability to control use under any circumstance	**5**

Recovery Environment

Factors in the environment that may contribute to the onset or maintenance of addiction or mental illness, and factors that may support a person's efforts to achieve or maintain mental health and/or abstinence. **For persons being treated in residential settings, ratings should be based on the conditions that would be encountered upon transitioning to a new or returning to the usual environment, whichever is most appropriate to the circumstances**.

Low Stress Environment • Essentially no significant or enduring difficulties in interpersonal interactions and significant life circumstances • No recent transitions of consequence • Has experienced no recent major losses of interpersonal relationships or material status • Material needs are met without significant cause for concern that they may diminish in the near future, and no significant threats to health or safety are apparent • Living environment poses no significant threats or risk • No pressure to perform beyond capacity in social role	**1**

Mildly Stressful Environment • Presence of some ongoing or intermittent interpersonal conflict, alienation, or other difficulties • A transition that requires adjustment such as change in household members or a new job or school • Circumstances causing some distress such as a close friend leaving town, conflict in or near current habitation, or concern about maintaining personal well-being • A recent onset of a transient but temporarily disabling or debilitating illness or injury • Potential for exposure to alcohol and/or drug use exists • Performance pressure (perceived or actual) in school or employment situations creating discomfort	**2**
Moderately Stressful Environment • Significant discord or difficulties in family or other important relationships or alienation from social interaction • Significant transition causing disruption in life circumstances • Recent important loss or deterioration of interpersonal or material circumstances • Concern related to sustained decline in health status • Danger in or near habitat • Easy exposure and access to alcohol and drug use • Perception that pressure to perform surpasses ability to meet obligations in a timely or adequate manner	**3**
Highly Stressful Environment • Serious disruption of family or social milieu • Severe disruption in life circumstances • Inability to meet needs for physical and/or material well-being • Recent onset of severely disabling or life-threatening illness • Difficulty avoiding exposure to active users and other pressures to partake in alcohol or drug use • Episodes of victimization or direct threats of violence near current home • Overwhelming demands to meet immediate obligations are perceived	**4**
Extremely Stressful Environment • An acutely traumatic level of stress or enduring and highly disturbing circumstances disrupting ability to cope with even minimal demands in social spheres • Unavoidable exposure to drug use and active encouragement to participate in use • Incarceration or lack of adequate shelter • Severe pain and/or imminent threat of loss of life due to illness or injury • Sustained inability to meet basic needs for physical and material well-being • Chaotic and constantly threatening environment	**5**

Highly Supportive Environment • Abundant sources of support with ample time and interest to provide for both material and emotional needs in all circumstances • Effective involvement of Assertive Community Treatment Team (ACT) or other similarly highly supportive resources	**1**
Supportive Environment • Supportive resources are not abundant but are capable of and willing to provide significant aid in times of need • Some elements of the support system are willing and able to participate in treatment if requested to do so and have capacity to effect needed changes • Professional supports are available and effectively engaged	**2**
Limited Support in Environment • A few supportive resources exist in current environment and may be capable of providing some help if needed • Usual sources of support may be somewhat ambivalent, alienated, difficult to access, or have a limited amount of resources they are willing or able to offer when needed • Persons who have potential to provide support have incomplete ability to participate in treatment and make necessary changes • Resources may be only partially utilized even when available • Limited constructive engagement with any professional sources of support that are available	**3**
Minimal Support in Environment • Very few actual or potential sources of support are available • Usual supportive resources display little motivation or willingness to offer assistance or they are dysfunctional or hostile toward client • Existing supports are unable to provide sufficient resources to meet material or emotional needs • Client may be alienated and unwilling to use supports available in a constructive manner	**4**
No Support in Environment • No sources for assistance are available in environment either emotionally or materially	**5**

Treatment and Stability History

A client's historical experience provides some indication of how that client is likely to respond to similar circumstances in the future. Most recent experiences in treatment and stability should take precedence over more remote experiences.

Fully Responsive to Treatment and Recovery Management • There has been no prior experience with treatment or recovery • Prior experience indicates that efforts in all treatments that have been attempted have been helpful in controlling the presenting problem. • There has been successful management of extended recovery with few and limited periods of relapse even in unstructured environments or without frequent treatment	**1**
Significant Response to Treatment and Recovery Management • Previous or current experience in treatment has been successful in controlling most symptoms but intensive or repeated exposures may have been required • Recovery has been managed for moderate periods with limited support or structure	**2**
Moderate or Equivocal Response to Treatment and Recovery Management • Previous or current treatment has not achieved complete remission of symptoms or optimal control of symptoms • Previous treatment exposures have been marked by minimal effort or motivation and no significant success or recovery period was achieved • Equivocal response to treatment and ability to maintain a significant recovery • At least partial recovery has been maintained for moderate periods, but only with strong professional or peer support or in structured settings	**3**
Poor Response to Treatment and Recovery Management • Previous or current treatment has not achieved complete remission of symptoms or optimal control of symptoms even with intensive and/or repeated exposure • Attempts to maintain whatever gains that can be attained in intensive treatment have limited success, even for limited time periods or in structured settings	**4**

Negligible Response to Treatment — **5**

- Past or current response to treatment has been quite minimal, even with intensive medically managed exposure in highly structured settings for extended periods of time
- Symptoms are persistent and functional ability shows no significant improvement despite this treatment exposure

Engagement

Considers the client's understanding of illness and treatment and ability or willingness to engage in the treatment and recovery process

Optimal Engagement — **1**

- Complete understanding and acceptance of illness and its effect on function
- Shows strong desire to change
- Is enthusiastic about treatment, is trusting, and shows strong ability to utilize available resources
- Understands recovery process and personal role in a successful recovery plan

Positive Engagement — **2**

- Significant understanding and acceptance of illness and attempts to understand its affect on function
- Willingness to change
- Engages in treatment in a positive manner, capable of developing trusting relationships, and will use available resources independently when necessary
- Shows some recognition of personal role in recovery and accepts some responsibility for it

Limited Engagement — **3**

- Some variability or equivocation in acceptance or understanding of illness and disability
- Has limited desire or commitment to change
- Relates to treatment with some difficulty and establishes few, if any, trusting relationships
- Does not use available resources independently or only in cases of extreme need
- Has limited ability to accept responsibility for recovery

Minimal Engagement — **4**

- Rarely, if ever, able to accept reality of illness or any disability that accompanies it
- Has no desire to adjust behavior
- Relates poorly to treatment and treatment providers and ability to trust is extremely narrow
- Avoids contact with and use of treatment resources if left to own devices
- Does not accept any responsibility for recovery

Unengaged — **5**

- No awareness or understanding of illness and disability
- Unable to understand recovery concept or contributions of personal behavior to disease process
- Unable to actively engage in treatment and has no current capacity to relate to another or develop trust
- Extremely avoidant, frightened, or guarded

Risk of Harm

A person's potential to cause significant harm to self or others. May consider past history of dangerous behaviors, ability to contract for safety, and availability of means. When considering historical information, recent patterns of behavior should take precedence over patterns reported from the remote past.

Minimal Risk of Harm — **1**

- No indication of suicidal or homicidal thoughts or impulses and no history of suicidal or homicidal ideation, and no indication of significant distress
- Clear ability to care for self now and in the past

Low Risk of Harm — **2**

- No current suicidal or homicidal ideation, plan, intentions or severe distress, but may have had transient or passive thoughts recently or in the past
- Substance use without significant episodes of potentially harmful behaviors
- Periods in the past of self-neglect without current evidence of such behavior

Moderate Risk of Harm — **3**

- Significant current suicidal or homicidal ideation without intent or conscious plan and without past history
- No active suicidal/homicidal ideation, but extreme distress and/or a history of suicidal/homicidal behavior exists
- History of chronic impulsive suicidal/homicidal behavior or threats and current expressions do not represent a significant change from baseline
- Binge or excessive use of substances resulting in potentially harmful behaviors without current involvement in such behavior
- Some evidence of self-neglect and/or compromise in ability to care for oneself in current environment

Serious Risk of Harm • Current suicidal or homicidal ideation with expressed intentions and/or past history of carrying out such behavior but without means for doing so, or with some expressed inability or aversion to doing so, or with ability to contract for safety • History of chronic impulsive suicidal/homicidal behavior or threats with current expressions or behavior representing a significant elevation from baseline • Recent pattern of excessive substance use resulting in disinhibition and clearly harmful behaviors with no demonstrated ability to abstain from use • Clear compromise of ability to care adequately for oneself or to be adequately aware of environment	**4**
Extreme Risk of Harm • Current suicidal or homicidal behavior or such intentions with a plan and available means to carry out this behavior • Repeated episodes of violence toward self or others, or other behaviors resulting in harm while under the influence of intoxicating substances with a pattern of nearly continuous and uncontrolled use • Extreme compromise of ability to care for oneself or to adequately monitor environment with evidence of deterioration in physical condition or injury related to these deficits	**5**

Continued Stay Criteria for SL and LTR

LOCUS Criteria

Supervised Living Level of Care (LOCUS = Monitored Non-Residential Services)

Evaluation Area	Rating
Functional Status	3 or less. 4 is possible if 1 on Recovery Environment.
Co-Morbidity	3 or less. 4 is possible if 1 on Recovery Environment.
Recovery Environment, Stress	3 or less
Recovery Environment, Support	3 or less
Treatment and Recovery History	3 or less. 4 if 1 on Recovery Environment.
Engagement	3 or less. 4 if 1 on Recovery Environment.
Risk of Harm	3 or less. Higher than 3 should not be managed at this level.
Composite score	17-21

Long-Term Rehabilitation Level of Care (LOCUS = Medically Monitored Residential Services)

Evaluation Area	Rating
Functional Status	4 requires this level of care independently of other scores unless 1 on Recovery Environment.
Co-Morbidity	4 requires this level of care independently of other scores unless 1 on Recovery Environment.
Recovery Environment	4 or higher in conjunction with 3 on either Risk of Harm, Functional Status, or Co-Morbidity requires this level of care.
Treatment and Recovery History	3 or higher in conjunction with 3 on either Risk of Harm, Functional Status, or Co-Morbidity requires this level of care.
Engagement	3 or higher in conjunction with 3 on either Risk of Harm, Functional Status, or Co-Morbidity requires this level of care.
Risk of Harm	4 requires this level of care independently of other scores.
Composite Score	22-26

LTR/SL/INTENSIVE SUPPORTED HOUSING
RESIDENTIAL SERVICES TRACKING
KING COUNTY REGIONAL SUPPORT NETWORK/MENTAL HEALTH PLAN

FACILITY CODES:

	LTR		SL
148	Transitional Resources	124	Briarwood
165	Cascade Hall	164	Spring Manor
166	Chartley House	165	Cascade Hall
167	El Rey	167	El Rey
219	Benson Heights	168	The Inn
221	High West	169	Keystone
224	Stillwater	173	Summit Inn
	Intensive Supported Housing		
225	Midway Residential		

Standard Supportive Housing (SSH) Transition Form

King County

USE THIS FORM for these client status changes only. CHECK ONE:

- ☐ Step down from LTR to SSH
- ☐ Step down from SL to SSH
- ☐ Step up from SSH to LTR when client has been in SSH less than 90 days
- ☐ Step up from SSH to SL when client has been in SSH less than 90 days
- ☐ Transfer from one SSH provider to another SSH provider
- ☐ Second-Priority SSH Referral (LIAISON USE ONLY)

DO NOT USE THIS FORM for any other status changes. For certain levels of care, the following forms may be useful instead:
Residential Treatment Services Placement Request, also known as Residential Application (Section VII, Attachment F of KCMHP P&P)
Residential Treatment Services Screening Form, also known as Level of Care (Section VII, Attachment A of KCMHP P&P)

Client Name: _____ **KCID:** _____

Referral Source: _____
Referral Source Contact Information: **phone** _____ **fax** _____
Current Agency Name: _____
Current Facility Name, if applicable: _____

Diagnoses: **Axis I:** _____
_____
Axis II: _____
_____
Axis III: _____
_____

Current/Historical Substance Use, if any: *(specify substances, frequency, last use)* _____
_____
_____

Client Preferences
Rank each location and/or setting type by client preference. Use 1 for first choice and 2 for second.

Location
___ Urban/City Location
___ Suburban Location

Setting *(complete only for transition into SSH)*
___ Independent Setting
___ Cluster or Group Setting

Specific City or Area Preferred? _____

Financial Screening
Client is eligible for: ☐SSI ☐SSDI ☐Disability Lifeline ☐GAX ☐Medicaid ☐Medicare ☐Other: _____
Monthly income: $_____ per month **Total amount of relevant resources (assets):** $_____

Rationale for Change in Status
Describe relevant events from the past 30-90 days as well as related interventions provided/attempted.
Relevant behaviors, symptoms, and events during the most recent 30-90 days *(2-3 paragraphs)*
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Relevant behaviors, symptoms, and events during the most recent 30-90 days *continued*

Relevant interventions provided during the most recent 30-90 days *(2-3 paragraphs)*

Functional Status Summary

Address relevant risks/progress/current functioning in self-care, community living, psychiatric medication issues, interpersonal behavior, dangerous/aggressive behaviors, sustained attention, mood symptoms, and psychotic symptoms. (2-3 paragraphs).

Felony History

List and/or describe all felony convictions on the client's record.

Required Packet Contents

Attach the following documentation to support the functional status summary and clinical summary.

- ☐ all psychiatric notes and/or evaluations from the past 90 days, including a list of current medications
- ☐ all progress notes from the past 30 days *(additional notes may be requested by the receiving provider or King County MHCADSD)*
- ☐ up-to-date individual service plan
- ☐ documentation of any emergency room visits or hospitalizations during the past 90 days
- ☐ releases of information for all relevant current providers, including outpatient mental health if applicable

- *The referent must send the form and packet to the liaison in all cases, except when a client is stepping down to SSH without changing providers.*
- *When the step-down to SSH occurs without a provider change, this form is placed in the clinical chart, and the clinical packet is not required. However, the liaison must be informed of the client's transition into SSH.*
- *When this form is completed by the referent, neither the Residential Treatment Services Placement Request nor the Residential Treatment Services Screening Form are required.*
- *When this form is completed by the liaison after receiving a Residential Treatment Services Placement Request for a second-priority client, the Residential Treatment Services Screening Form is not required.*
- *When this form is being used to facilitate movement of a client from SSH into SL or LTR after the client has been in SSH less than 90 days, or for placement of a second-priority client into SSH, the liaison must submit the form and packet to King County MHCADSD Clinical Services for prior review and approval.*

Fax Form to:
Clinical/Residential Specialist
(206) 205-1634

King County

RESIDENTIAL ABSENCE AUTHORIZATION

CLIENT'S NAME: _____ KCID: _____ DOB: _____

FACILITY NAME: _____ PHONE: _____

FORM COMPLETED BY: _____ DATE: _____

ABSENCE REASON

o HOSPITALIZATION (BEYOND FIVE WORKING DAYS)
- MEDICAL (name of hospital): _____
- PSYCHIATRIC (name of hospital): _____
- DATE OF ADMISSION: _____
- ANTICIPATED RETURN DATE: _____

APPROVED FOR RESIDENTIAL BED HOLD? ☐Y ☐N

BED TO BE HELD UNTIL: _____

KING COUNTY AUTHORIZATION: _____ DATE: _____

SOCIAL ABSENCE

o SOCIAL LEAVE (BEYOND FIVE WORKING DAYS)

- DATE CLIENT LEFT: _____
- PLANNED LEAVE: ☐Y ☐N CONSISTENT WITH CLIENT'S ISP? ☐Y ☐N
- UNPLANNED LEAVE ☐Y ☐N

  CLIENT'S CURRENT LOCATION: ☐JAIL

  ☐CD INPATIENT

  ☐UNKNOWN

APPROVED FOR RESIDENTIAL BED HOLD? ☐Y ☐N

BED TO BE HELD UNTIL: _____

KING COUNTY AUTHORIZATION: _____ DATE: _____

VIII. INPATIENT SERVICES LEVEL OF CARE

1.0 POLICY TITLE: INPATIENT SERVICES LEVEL OF CARE

1.1 Originally Implemented: April 1, 1995

1.2 Reviewed and revised: November 2014

1.3 Officially Adopted: January 2, 2015

1.4 Effective Date: February 2, 2015

1.5 Signed: _____
Jean Robertson, Assistant Division Director/RSN Administrator

2.0 PURPOSE: To describe the community-based inpatient services level of care within the King County Mental Health Plan (KCMHP) and the additional inpatient services managed by the King County Regional Support Network (RSN) that are provided through other state-funded medical programs. This includes both voluntary and involuntary inpatient services.

3.0 POLICY/PROCEDURES/RESPONSIBILITIES FOR ACCESS TO SERVICES:

3.1 Financial Eligibility

3.1.1 Voluntary Inpatient Care

A. Any person who is eligible for Medicaid or any other state Health Care Authority medical program that covers psychiatric inpatient care, and who resides in King County, is eligible for inpatient services through the KCMHP.

B. In circumstances where the person's county of residence is unclear, hospitals shall use Attachment A: Which RSN Should a Hospital Call? to determine which RSN to contact for the authorization of care.

C. When the identity of the responsible RSN still cannot be determined and a delay in authorization may negatively impact the acute and emergent care of the individual, KCMHP may choose to authorize or deny an admission so the referred person may proceed to needed care. If it is later determined that the responsible RSN is other than King County, the responsible RSN will abide by the KCMHP decision.

D. Persons new to Washington State

1. If the person is currently receiving Medicaid from another state, King County will not authorize the admission. The hospital must seek payment from this other state.

2. If the person currently has no coverage (and appears to be the responsibility of King County per Attachment A), KCMHP will accept an authorization request. (It is up to HCA, not KCMHP, to determine if the person qualifies for an HCA medical program.)

3.1.2 Involuntary Inpatient Care

Any person of at least 13 years of age currently present in King County (no matter where the person resides) may be evaluated by King County Designated Mental Health Professionals (DMHPs) for involuntary inpatient care. The KCMHP is responsible for payment for those persons who reside in King County and for whom no other source of funding is available.

3.1.3 State Hospital Care

Admission, discharge, and treatment planning for adults at state psychiatric hospitals are governed by federal regulations and state requirements. KCMHP does not authorize involuntary admissions to state psychiatric hospitals. However, KCMHP will approve both voluntary and involuntary admissions to a state hospital in coordination with the community hospital and the state hospital.

3.1.4 Children's Long-term Inpatient Programs (CLIP)

A. The KCMHP Clinical Team and the appropriate Community Resource Team will conduct an initial screening and must approve voluntary applications for children considered for these long-term psychiatric inpatient programs, prior to a CLIP referral. (Youth placed on 180-day more restrictive involuntary orders are considered eligible for CLIP admission.)

B. The DSHS-sponsored CLIP Administration will conduct the Title XIX certification of medical necessity for voluntary admissions to CLIP.

C. KCMHP will facilitate appropriate treatment and discharge planning for children served in CLIP, and will assure that Wraparound is offered to these children and families.

3.2 Medical Necessity

3.2.1 Voluntary Inpatient Care

A. Medical necessity for the inpatient level of care requires:

1. Ambulatory care resources available in the community do not meet the treatment needs of the individual; and

2. Proper treatment of the person's psychiatric condition requires services on an inpatient basis under the direction of a physician (according to Washington Administrative Code [WAC] 246-322-170 or its successor); and

3. The services can reasonably be expected to improve the person's level of functioning or prevent further regression of functioning; and

4. The person has been diagnosed as having an emotional/behavioral disorder or a severe psychiatric disorder (as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association) that is considered a principal covered diagnosis (see below) and warrants care in the most intensive and restrictive setting; or

5. The person was evaluated and met the criteria for emergency involuntary detention (Chapter 71.05 or 71.34 Revised Code of Washington (RCW) or its successor) and agreed to inpatient care.

B. Only persons who meet diagnostic criteria for the following diagnoses can be authorized for voluntary inpatient care:

290 Senile and presenile organic psychotic conditions;

291 Alcoholic psychoses;

292 Drug psychoses;

293 Transient organic psychotic conditions;

294 Other organic psychotic conditions (chronic);

295 Schizophrenic psychoses;

296 Affective psychoses;

297 Paranoid psychoses;

298 Other non-organic psychoses;

299 Psychoses with origin specific to childhood;

300 Neurotic disorders;

301 Personality disorders

306 Physiological malfunction arising from mental factors

307 Special symptoms or syndromes not elsewhere classified (includes eating disorders)

308 Acute reaction to stress;

309 Adjustment reaction;

310 Specific non-psychotic mental disorders due to organic brain damage;

311 Depressive disorder, not elsewhere classified;

312 Disturbance of conduct not elsewhere classified;

313 Disturbance of emotions specific to childhood and adolescence; and

314 Hyperkinetic syndrome of childhood.

C. When they are the sole diagnosis and/or the main focus of treatment, the following disorders cannot be approved, unless the person has a Medicare coverage that has not been exhausted:

302 Sexual deviations disorders;

303 Alcohol dependence syndrome;

304 Drug dependence;

305 Nondependent abuse of drugs;

315 Specific delays in development;

316 Psychiatric factors associated with diseases classified elsewhere; and

317-319 Mental retardation.

3.2.2 Involuntary Inpatient Care

Medical necessity is determined according to the criteria in Chapter 71.05 RCW for adults and Chapter 71.34 RCW for youth, or their successors.

3.3 Authorization for the Inpatient Level of Care

3.3.1 Voluntary Inpatient Care

A. The individual must be evaluated within 24 hours prior to a request for admission by the mental health professional requesting the authorization. Mental health professional is defined in RCW 71.05.020 and Chapter 388-877-0200 WAC or its successor.

1. In extraordinary circumstances, the KCMHP may accept an evaluation by an emergency room physician or a contracted provider staff person who is not a mental health professional according to the discretion of the KCMHP care authorizer.

2. Hospitals that routinely request authorizations from the KCMHP and do not have in-house mental health professionals may seek a waiver of this requirement, if they can demonstrate that other staff can perform an adequate client assessment and according to agreed-upon guidelines.

B. If a hospital seeks an authorization after admission and within the first 24 hours of admission, the authorization will be backdated to begin on the actual date of admission.

C. When evaluating someone for a possible voluntary inpatient admission, the mental health professional shall determine:

1. Whether the person is currently authorized for a KCMHP outpatient level of care (if not otherwise available, this information can be obtained from the Crisis Clinic);

    a. For persons authorized to the outpatient level of care, the evaluating mental health professional will request from the provider clinical information regarding the client's diagnosis, outpatient individual service plan, standardized crisis plan if applicable, advance directive if available, current mental health care provider, current prescriber, and other information pertinent to establishing medical necessity, including any recent failure of less restrictive alternatives to hospitalization. Outpatient provider staff shall assist with phone consultation and/or outreach to an emergency department as outlined in Section VI.

    b. For persons who receive outpatient mental health treatment from a non-KCMHP provider, the evaluating mental health professional will attempt to contact that provider to determine that person's recommendations about admission and treatment.

2. Whether immediate provision of a covered state plan outpatient service can avert the hospitalization;

3. Whether a crisis or respite bed or other crisis service can avert the hospitalization and, if so, the availability of such services;

4. Whether other settings might more appropriately meet the needs of the person, such as an inpatient medical unit, detoxification unit, or intensive substance use disorder treatment services, and, if so, the availability of such services; and

5. Whether and where an inpatient psychiatric bed is available, should the admission be authorized.

D. The mental health professional shall determine that medical necessity is met as follows:

1. The person has been given the diagnosis of a covered mental illness;

2. The proposed inpatient treatment plan must be expected to improve the person's condition or prevent further regression so that the inpatient services are no longer needed;

3. The treatment plan is evaluated according to the following elements: goals for the hospitalization; likelihood that the goals can be accomplished within the usual timeframe for an acute hospitalization; proposed interventions; the person's advance directive, if available; treatment history, if available; continuity with any current outpatient plan; and, when available, a proposed discharge plan;

4. The treatment plan must also fulfill the state definition of medical necessity: "A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. For the purpose of this section, 'course of treatment' may include mere observation, or, where appropriate, no treatment at all." (WAC182-500-0070 or its successor); and

5. Outpatient services available in the community do not meet the needs of the person and/or the condition requires services that can be provided only on an inpatient basis.

    a. The needs of the person are evaluated according to the following parameters: risk of harm or dangerousness, functional status, co-morbidity, stressors, supports, and motivation for treatment.

    b. For intoxicated persons, these parameters need to be assessed after a reasonable degree of sobriety is attained.

E. Hospital days may be authorized for persons who do not meet usual authorization criteria if the inpatient treatment plan is part of an outpatient Individual Service Plan (ISP) that has been pre-approved by KCMHP or the person's needs fit other special circumstances approved by KCMHP.

F. Number of days in the initial authorization

   The number of days authorized in the initial authorization is based upon the acuity and complexity of the needs of the person. The KCMHP care authorizer will:

   1. Utilize the LOCUS/CALOCUS to assess acuity; and

   2. Authorize three, four or five initial days based upon acuity level, day of the week, and the imminent risk of harm to self or others. Weekends or holidays that will occur during the anticipated stay may increase the initial days to a maximum of five days.

G. The procedure for an admission authorization is as follows:

1. The requesting mental health professional shall call the KCMHP authorization line at 206-461-4858 or 1-800-790-8049. This number is operational 24 hours a day, 7 days a week for referrals requesting authorization for inpatient admissions;

2. The KCMHP care authorizer will speak to the mental health professional immediately or within 15 minutes, if the caller must leave a message;

3. The KCMHP care authorizer must be a mental health professional as defined in RCW 71.05.020 and Chapter 388-877-0200 WAC or its successor;

4. The KCMHP care authorizer will have access to the MHCADSD IS;

5. The KCMHP care authorizer will require the following clinical information in order to assess authorization criteria. If medical necessity is evident, the care authorizer may tailor the assessment to effect a faster disposition;

   a. Date of proposed or actual admission;

   b. Proposed hospital. Persons shall be authorized to an inpatient facility in King County unless the KCMHP care authorizer determines that appropriate treatment is not available in this County.

   c. Mental health condition parameters as noted above;

   d. Preliminary diagnosis(es); and

   e. Recommended length-of-stay to accomplish target goals of treatment plan, if known;

6. If the person being referred is a child and the KCMHP care authorizer is not a child mental health specialist, as defined in WAC 388-865-0150 or its successor, the clinical information will be reviewed by such a specialist; and

7. The KCMHP care authorizer must complete Attachment B: Daily Authorization Log documenting the authorization and submit it to the receiving hospital by the next business day.

H. Timelines for inpatient authorization decisions are as follows:

1. 90 percent of all decisions concerning the initial authorization of an acute and emergent admission shall be made within one hour of the initial call;

2. 95 percent of decisions shall be made within three hours of the initial call; and

3. 90 percent of decisions made in response to calls from DMHPs shall be made within one hour of the request.

I. In all cases, a KCMHP care authorizer must respond to a request for an initial authorization within two hours of the initial request and make an authorization decision within 12 hours of the initial request.

J. For any type of authorization decision, KCMHP may defer immediate decision-making in the absence of medical necessity information that justifies an approval. If the information is not received within 12 hours of the request, the authorization request will be categorized as either cancelled or withdrawn, not denied.

K. Once given, inpatient authorizations are not terminated, suspended, or reduced.

L. Unless approved by the KCMHP care authorizer, an authorization expires when 24 hours have passed without the client receiving hospital services.

M. Denials

1. A denial occurs ONLY when the hospital believes medical necessity is met for the inpatient level of care and the KCMHP care authorizer disagrees and therefore does not authorize the care.

2. Only a KCMHP psychiatrist may issue a denial.

3. Alternatively, a diversion (or "negotiated diversion") is when, following the recommendation of the KCMHP care authorizer, the hospital agrees to another level of care. A diversion can occur prior to admission or during a continued stay review.

4. When care is not authorized, either at the time of admission, during an admission, or following an admission, for reasons other than disagreements over medical necessity, this is not considered a denial (and need not be issued by a KCMHP psychiatrist).

N. Expedited reviews

1. Prior to finalizing a denial and on the request of the referring professional, the KCMHP will perform an expedited review of the denial decision. This review is a phone discussion of medical necessity between the referring professional and a KCMHP psychiatrist.

2. Additionally, in the 24 hours following a denial of an authorization for admission or for a length-of-stay extension, the referring mental health professional or the hospital staff may request an expedited review.

O. If an inpatient authorization request is denied and the client is not admitted, a new admission authorization request may be made at any time, if:

1. A new assessment of the client reveals that the clinical issues have changed such that the client now meets medical necessity criteria; and/or

2. A new assessment of the client reveals significant information not obtained during the first assessment, such that the client meets medical necessity criteria after all.

P. Special Circumstances

1. Application for HCA medical program coverage during the course of the hospitalization.

a. Hospitals must notify the KCMHP care authorizer within 24 hours of any person who applies for HCA medical program coverage.

b. At the time of notification, the KCMHP care authorizer will process the authorization request (for the current day and any future days) within 12 hours.

c. Authorization of any days that occurred prior to the notification may be considered as a retrospective review.

2. Change in primary diagnosis

a. Hospitals have 24 hours to notify the KCMHP care authorizer whenever a hospitalized person's diagnosis changes to one that is no longer covered. The care authorizer will handle this notification as a notification of discharge. Any days authorized that have not yet occurred will not be covered.

b. Hospitals have 24 hours to notify the KCMHP care authorizer whenever a hospitalized person's diagnosis changes from one that is not covered to one that is. The care authorizer will consider this notification as an initial authorization request.

3. Electroconvulsive therapy (ECT)

a. Hospitals shall seek approval by the KCMHP care authorizer before initiating a course of ECT during a voluntary inpatient stay that has already been authorized.

b. If ECT is initiated without KCMHP approval, any subsequent length-of-stay authorization requests will be approved only if the ECT meets KCMHP standards of care.

4. Medicare

    a. For persons who have both Medicaid and Medicare coverage (that is not exhausted) at the time of the admission, the hospital must inform the KCMHP care authorizer that the admission is occurring but need not seek authorization. For this notification, hospitals should use Attachment C: Form for Notification of Medicare or Commercial Insurance.

    b. For persons who have Medicaid and Medicare coverage (but it is exhausted at the time of the admission), the hospital must seek authorization for the admission as it would for a person who had only Medicaid.

    c. For persons who have Medicaid and Medicare coverage, where the Medicare coverage becomes exhausted during the course of an admission, the hospital must seek authorization no later than the calendar day of the benefit exhaustion. The KCMHP care authorizer will respond to the request within 2 hours and make an authorization decision within 12 hours.

    d. For persons who have Medicare but apply for Medicaid during the course of a hospitalization:

        i. If Medicare will not be exhausted during the admission, no action is required; and

        ii. If Medicare is exhausted or may be exhausted during the stay, the hospital must seek authorization at the time of the application or at the time of the exhaustion of benefits, whichever occurs last.

    e. When a hospital is unclear about the exhaustion of a person's Medicare coverage and the person has Medicaid, the hospital may:

        i. Confirm Medicare exhaustion on the next business day; and

        ii. Then, if benefits are exhausted, seek an authorization. As long as the hospital seeks the authorization after an attempt to determine exhaustion and by the end of the next business day, KCMHP will process the authorization from the date of admission.

    f. If a Medicare Part C plan has determined that a voluntary person with both Medicare and Medicaid (or any other coverage managed by KCMHP) no longer meets medical necessity, KCMHP will also consider this person as not meeting medical-necessity criteria.

5. Private or commercial insurance

    a. For persons who have both Medicaid and unexhausted private coverage at the time of the admission, the hospital must:

        i. Seek authorization, if Medicaid will be paying for any part of the stay; or

        ii. Inform the KCMHP care authorizer that the admission is occurring, if Medicaid will not be paying for any part of the stay. For this notification, hospitals should use Attachment C: Form for Notification of Medicare or Commercial Insurance.

    b. If Medicaid has not been paying a co-pay and the private coverage becomes exhausted during the admission, the hospital must seek authorization no later than the calendar day of the benefit exhaustion. The KCMHP care authorizer will respond to the request within 2 hours and make an authorization decision within 12 hours.

6. Transfers from one hospital to another

    a. Prior to the transfer, the hospital that has been caring for the patient shall seek authorization for the care of the patient at the receiving hospital.

    b. The KCMHP care authorizer will make a decision about authorizing days at the receiving hospital within 24 hours of receiving this request.

7. Change in legal status

    a. When a client changes from involuntary to voluntary or from voluntary to involuntary, the hospital must notify the KCMHP care authorizer by the next business day. For this notification, hospitals should use Attachment D: Form for Change in Legal Status.

    b. Days authorized at the time of a legal status change (from involuntary to voluntary or from voluntary to involuntary) will not be rescinded.

8. Children

    a. Children 13 years of age or older can be admitted for treatment with their written consent if the treatment facility's professionals agree and parents or guardians are not available. Parent(s)/ guardian(s) must be notified of such an admission and they have the right to demand release unless the treatment facility petitions the court, or the youth has requested that the parent not be notified.

b. A minor (any person under age 18) may be voluntarily admitted by application of the parent or guardian. The consent of the minor is not required for the minor to be evaluated and admitted as appropriate.

Q. Retrospective authorizations of voluntary admissions

1. A retrospective authorization may occur when an inpatient day was provided without a previous request for authorization.

2. Requests for retrospective authorization will be considered only:

   a. When the person applies for HCA medical program coverage during the course of the hospitalization (for the days which have occurred prior to the application) or following discharge; or

   b. When the failure to request a prior authorization occurred for reasons beyond the control of the hospital.

      At a minimum, hospitals are expected to do the following:

      i. Provide coverage for utilization management staff when lead staff is unavailable;

      ii. Make an electronic or phone inquiry as to a patient's coverage by a private insurer, Medicare (especially a Medicare Advantage Program), or a HCA medical program no later than the first hours of an admission, to ensure there is adequate time to request an authorization by KCMHP if needed;

      iii. Determine as accurately as possible whether a Medicare patient has exhausted his/her inpatient benefits; and

      iv. Confirm KCMHP authorizations prior to accepting a patient in transfer from another facility.

3. Once a determination has been made that the above circumstances do not apply, the determination cannot be appealed.

4. When a retrospective authorization request is made during an inpatient stay:

   a. The KCMHP care authorizer will consider for authorization only the current day and any future days.

   b. The decision will be made according to the time frames for an initial authorization.

   c. After discharge, the hospital must make a separate request that the days provided prior to the retrospective request be considered for authorization.

5. When a retrospective authorization request is made after discharge (either for the whole hospital stay or for the days that were provided prior to a first retrospective request that was made during the inpatient stay).

    a. The hospital must request the retrospective authorization in writing within 30 calendar days of the discharge of the client. The medical record for the entire hospitalization must accompany the request.

    b. A retrospective authorization request that is not received within 30 calendar days will not be considered, unless:

        i. The person applied for retrospective coverage by a DSHS medical program after this deadline. In that case, the deadline may be waived if the hospital can provide documentation of the date of application and if the hospital makes the retrospective authorization request within 30 days of this date; or

        ii. The person appeared to have out-of-state Medicaid at the time of the admission but had initiated a transfer of benefits to King County prior to the admission. In that case, the deadline may be waived if the hospital can provide documentation of the date of initiation of the transfer of benefits and if the hospital makes the retrospective authorization request within 30 days of this date.

    c. Retrospective authorization requests and the medical record must be submitted to the KCMHP care authorizers. The record must be accompanied by a letter stating the reason the hospital was unable to request authorization in advance, the rationale for the request for authorization, and must highlight those sections of the medical record that address this specific issue.

    d. The retrospective authorization decision will be based on the submitted medical record documentation.

    e. The KCMHP will complete the retrospective authorization determination within 30 calendar days, unless it appears that another RSN may be responsible for the admission. If that is the case, KCMHP will first work with the other RSN to determine responsibility and then, if KCMHP is responsible, process the retrospective request.

    f. A denial of a retrospective authorization for requests submitted after discharge may be appealed by either the person or the provider.

3.3.2 Involuntary Inpatient Care

A. Designated Mental Health Professionals (DMHPs) will assess and, when appropriate, detain persons age 13 and older referred for involuntary hospitalization.

B. Referrals by the DMHPs to hospitals and/or evaluation and treatment facilities will occur according to the Patient Placement Decision Trees. (See Attachments E: Patient Placement Decision Tree: Adults and Attachment F: Patient Placement Decision Tree: Juveniles.)

C. The DMHP decision to involuntarily detain a person to an inpatient facility signifies that medical necessity for inpatient care has been determined and the admission is authorized.

For other county residents detained in King County by King County DMHPs, the hospital must contact that other county for purposes of discharge planning.

D. All initial authorizations for involuntary care are for 20 days. The 20 days are counted from the date of detention, including days on non-psychiatric hospital units and days at other hospitals.

E. Hospitals who wish an authorization for involuntary care for an unfunded person documented in ProviderOne prior to discharge may request this by listing the person on Attachment H: Inpatient Client Information Form and faxing to the care authorizer.

1. This process is for unfunded persons only.

2. This is optional.

3. The client information will need to be resubmitted to the care authorization on discharge.

3.4 Continuing Stay Criteria and Authorization of Extensions

3.4.1 Authorization for continuing stay refers to the authorization of days of hospitalization beyond the days approved in the initial authorization. This is also called a “length-of-stay extension.”

3.4.2 For voluntary admissions

A. The criteria for a continued stay are the same as those for an authorization for admission.

B. The KCMHP will re-administer the LOCUS/CALOCUS for each length-of-stay extension request.

C. The length of an authorized extension is at the discretion of the KCMHP care authorizer.

D. The hospital may request as many length-of-stay (LOS) extensions as needed.

E. Extensions may be requested 48 hours in advance of, but not more than 24 hours after, the expiration of the current authorization. Whenever possible, hospitals are encouraged to submit extension requests during regular business hours.

F. KCMHP will make an authorization decision within 24 hours of receipt of the extension request.

G. On the request of the hospital, the KCMHP will perform an expedited review of a LOS denial decision. This review is a phone discussion of medical necessity between the hospital and a KCMHP psychiatrist. Requests for an expedited review must be made by noon of the next business day following a LOS denial.

H. If the KCMHP care authorizer is unable to make the authorization decision within 24 hours, the authorizer will authorize a single day while completing the authorization process.

I. The hospital must allow time for adequate discharge planning should an extension be denied.

J. Extensions may be authorized at the administrative daily rate when the following occur:

    1. The client has a legal status of voluntary;

    2. The client no longer meets medical-necessity criteria;

    3. The client no longer meets intensity-of-service criteria (continued stay solely for the purpose of medication adjustments does not justify payment at the full inpatient rate and may be denied or the administrative daily rate may be offered);

    4. Less restrictive alternatives are not available, posing a barrier to safe discharge; and

    5. The hospital and KCMHP care authorizer mutually agree to the appropriateness of the administrative day.

K. Hospitals are required to submit the Attachment G: Extension Request for Hospitalization Form to the KCMHP care authorizer in order to initiate an extension request.

L. Once the extension is approved or denied, the care authorizer documents the authorization decision and returns the form to the hospital.

3.4.3 For involuntary admissions

A. Hospitals (but not the state hospitals or the free-standing evaluation and treatment facilities) must request length-of-stay extensions for the care of all persons involuntarily committed beyond 20 days, if the client is not covered by Medicare and part of his/her stay is covered by public funds.

1. If a client is admitted as an involuntary client and converts to voluntary within the first 20 days, length-of-stay extension requests are not needed until the 20 days from detention are used; the initial authorization for 20 days remains in place.

2. If a client is admitted as a voluntary client and is detained during the days covered by the initial authorization (generally fewer than 20 days), length-of-stay extensions requests are needed whenever the days initially authorized are used; there is no 20-day authorization for these clients.

B. Hospitals are required to submit the Attachment G: Crisis Clinic Extension Request Form to the KCMHP care authorizer in order to initiate an extension request.

C. Once the extension is approved, the KCMHP care authorizer documents the authorization decision and returns the form to the hospital.

D. A KCMHP care authorizer may not deny any extension request for an involuntary person.

3.4.4 For both voluntary and involuntary hospitalizations, the KCMHP care authorizer will contact the KCMHP clinical team whenever a hospital requests a third length-of-stay extension so that the clinical team can offer the hospital assistance with the treatment and discharge plan.

3.5 Discharge and Termination

3.5.1 Discharge shall occur when a client no longer meets medical-necessity criteria for admission.

3.5.2 Once given, an inpatient authorization will not be terminated. However, a hospital may discharge a client before an authorization has expired.

3.5.3 When a client is discharged, the hospital must notify the KCMHP care authorizer using Attachment H: Inpatient Client Information Form.

3.6 Provider Appeals

3.6.1 In addition to pursuing an expedited review of a potential denial, a hospital may appeal a decision to deny an authorization or length-of-stay extension.

3.6.2 An appeal may be submitted whenever:

A. An inpatient day was provided despite a denial; or

B. An elective admission has been denied.

3.6.3 The authorization of administrative days may not be appealed.

3.6.4 Timelines for a provider appeal request are as follows:

A. When an inpatient day was provided despite a denial, the hospital must request an appeal in writing within 15 business days of the discharge of the client or receipt of a denial of a retrospective authorization request.

B. When an elective admission or an extraordinary psychiatric service has been denied, the hospital (or outpatient provider) must request an appeal in writing within 15 business days of the denial.

C. An appeal request that is not received within the specified 15 business days will not be considered.

3.6.5 The appeal request must contain the following:

A. When an inpatient day was provided despite a denial, the request must include the entire medical record available at the time of discharge for both initial authorization and length-of-stay extension appeals.

B. When an elective admission has been denied, the hospital (or outpatient provider) must send medical records documenting the need for the requested service.

C. In addition to the requested medical records, the hospital (or outpatient provider) must send a letter referencing the reason for the denial, the rationale for the appeal, and must highlight those sections of the medical record that address this specific issue.

3.6.6 Appeal requests and the medical record must be submitted to a KCMHP Medical Director.

3.6.7 The appeal decision will be based on the submitted medical record documentation.

3.6.8 The appeal decision may be based on factors beyond the original reason for denial.

3.6.9 The appeal decision will be made by a KCMHP Medical Director. This psychiatrist will not be the psychiatrist that issued the original denial and will not be in the KCMHP provider network.

3.6.10 KCMHP will respond in writing to the hospital within 30 days with the Medical Director’s determination.

3.6.11 All appeal decisions are final and binding.

3.6.12 When care is not authorized, either at the time of admission, during an admission, or following an admission, for reasons other than disagreements over medical necessity, as mentioned above, this is not considered a denial.

A. Such determinations cannot be appealed.

B. However, if the hospital thinks that the KCMHP care authorizer has deviated from published requirements, the hospital may take its dispute to the KCMHP Medical Director or designee. This must occur within 30 days of the client's discharge or of the KCMHP decision that is the topic of the dispute.

C. To initiate the dispute, hospital staff shall first call the KCMHP Medical Director, and then send any documentation requested during the phone call.

D. The KCMHP Medical Director shall respond to the dispute within 30 calendar days of receipt of the requested documentation.

E. Following this response, if the hospital continues to believe that KCMHP has deviated from published requirements, the hospital may take its dispute to DSHS/BHSIA/DBHR. DBHR decisions are final.

3.7 Notices of Action and appeals

Notices of Action are provided to persons who are voluntary and are covered by Medicaid only.

3.7.1 Adverse actions requiring a Notice of Action specific to the inpatient level of care include:

A. The denial of a provider (including hospital provider) request for an initial authorization for admission;

B. The denial of a hospital provider request for a length-of-stay extension;

C. The retrospective denial of authorization for payment for a hospital day that has already occurred.

3.7.2 The following are not considered adverse actions:

A. The failure to authorize a request due to a provider failure to provide adequate information;

B. The withdrawal of a request for inpatient services, either by the client or the provider. This includes a negotiated diversion from an inpatient admission;

C. The authorization of only part of the days requested in a length-of-stay extension, when the hospital has no restrictions from requesting additional days in the future;

D. The denial of admission to a specific hospital; and

E. The assignment of the administrative daily rate for an inpatient day.

3.7.3 When an adverse action occurs, both the person covered by Medicaid and the requesting provider will receive an inpatient Notice of Action. (See Attachment I.)

A. When a hospital has requested the services that are denied, the Notice of Action will go to the hospital.

B. When an outpatient provider has requested the inpatient services that are denied, the Notice of Action will go to the clinical director of the requesting agency.

C. If the person is not in the hospital and his/her address is provided to the KCMHP care authorizer, the Notice will be mailed to the client's home within three business days.

D. If the person is hospitalized, the Notice of Action will be faxed to the requesting provider (usually hospital staff) who will give a copy to the person immediately. If the provider is unable to provide a copy to the person immediately, he/she may deliver it or mail it to the client at a later time, as long as the person receives it within 14 calendar days of the denial. The provider shall document in the medical record the successful delivery of the Notice to the person.

3.7.4 A person, who is covered by Medicaid and has sought hospitalization, may appeal any KCMHP decision that leads to an inpatient Notice of Action.

3.7.5 See Section III: Client Rights for the client appeal process and other client rights and assistance due to persons who are or seek to be hospitalized.

4.0 POLICY/PROCEDURES/RESPONSIBILITIES FOR SERVICES:

4.1 Services

4.1.1 Services shall be provided according to all of the following values:

A. Cultural and linguistic competence

B. Orientation towards promoting recovery and resiliency

C. Appropriateness to the age and developmental stage of the individual

4.1.2 Services include:

A. Voluntary and involuntary inpatient care

B. Care to all ages

4.1.3 Service settings for this level of care include:

A. Freestanding psychiatric hospitals (IMDs);

B. Distinct part psychiatric inpatient units in community-based general hospitals;

C. Medical/surgical beds in community hospitals when active care is provided under the supervision of a psychiatrist; or

D. Freestanding evaluation and treatment (E&T) facilities certified by DSHS to provide inpatient care.

4.2 Clinical time frame requirements

As the inpatient level of care is considered "acute and emergent" in most instances, an admission shall occur within 24 hours of an authorization.

4.3 Documentation requirements

Documentation of services shall occur per licensing, certification, and accreditation requirements.

5.0 INFORMATION SYSTEMS BUSINESS RULES:

5.1 Financial rules

5.1.1 Hospitals (both general and specialized) are contracted with the state, not KCMHP.

5.1.2 Hospitals shall submit bills for care according to Inpatient Hospital Services Provider Guide, as published by the HCA.

5.1.3 Hospitals must provide KCMHP discharge information so that KCMHP can prepare the payment authorization in ProviderOne . This must be done for the following admissions:

A. All voluntary admissions authorized, in full or in part, by KCMHP. As KCMHP only authorizes hospitalizations for persons with Medicare when their Medicare has been exhausted, hospitals need to send only the information on the initial notification form to KCMHP on voluntary admissions of persons with unexhausted Medicare.

B. All involuntary admissions, unless the full cost of care, including ambulance service to court, is paid by the patient or his/her private insurance. In general, when a person with Medicare is involuntary and

requires ambulance service to court, HCA will need to be billed by the ambulance service, as Medicare does not pay for ambulance service to court. KCMHP needs the discharge information to prepare the payment authorization in ProviderOne.

5.1.4 To provide the discharge information, the hospital sends to the KCMHP care authorizer Attachment H: Inpatient Client Information Form. The KCMHP care authorizer has five business days from receipt of the hospital discharge information and the requisite eligibility determination (when applicable) by HCA to complete the payment authorizations in ProviderOne.

5.1.5 KCMHP will review HCA payments to hospitals to ensure that only authorized days are paid. Should any discrepancies be identified, KCMHP will notify fiscal staff at DBHR by the 5th day of each month following the previous month's claims.

5.1.6 Should the hospital be reimbursed for days not authorized, these funds will be recouped by the state HCA.

5.1.7 Out-of-state hospitals

A. For persons covered by Medicaid, payment may occur only when the hospital has followed all the requirements in this policy for in-state hospitals.

B. All out-of-state hospital admissions will be managed as voluntary admissions, as the Involuntary Treatment Acts apply only within the borders of Washington State.

C. Inpatient services for all other persons provided in an out-of-state hospital are not billable and will not be paid.

6.0 LIST OF ATTACHMENTS:

6.1 Attachment A: Which RSN Should a Hospital Call

6.2 Attachment B: Daily Authorization Log

6.3 Attachment C: Notification of Medicare or Commercial Insurance Form

6.4 Attachment D: Change in Legal Status Form

6.5 Attachment E: Patient Placement Decision Tree: Adults

6.6 Attachment F: Patient Placement Decision Tree: Juveniles

6.7 Attachment G: Extension Request for Hospitalization Form

6.8 Attachment H: Inpatient Client Information Form

6.9 Attachment I: Notice of Action for Inpatient Services

6.10 Attachment J: Notice of Determination for Inpatient Services

7.0 REFERENCES:

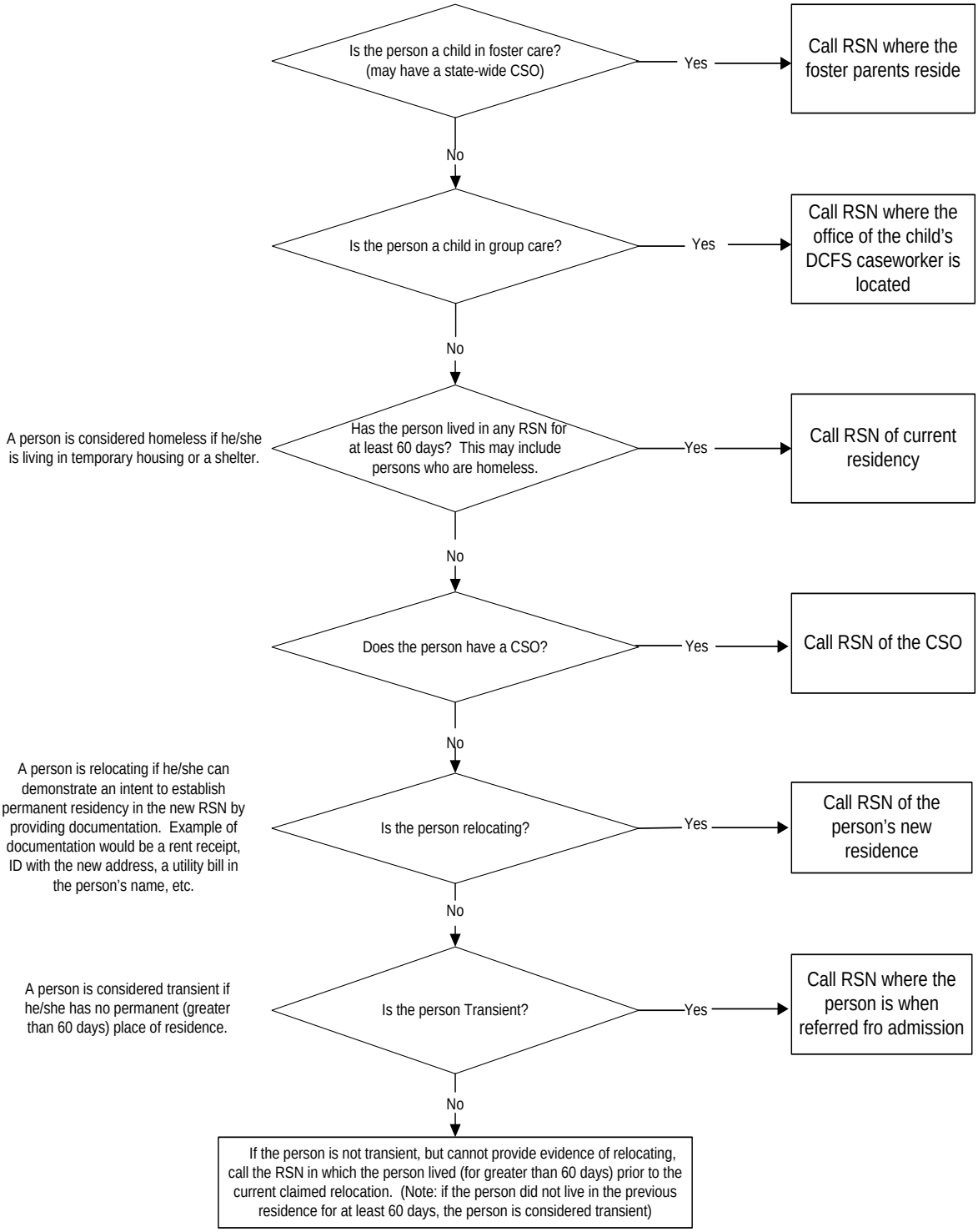
Washington State Law, Regulations, and Policy including any successor, amended, or replacement laws**,** regulations**,** or policies

- WAC 246-322-170 – Department of Health – Private Psychiatric and Alcoholism Hospitals – Patient Care Services
- WAC 284-43-322 – Office of the Insurance Commissioner – Health Carriers and Health Plans – Provider Contracts – Dispute Resolution Process
- WAC 182-500-0700 – Department of Social and Health Services – Medical Assistance – Medical Definitions
- WAC 182-550-2600 – Department of Social and Health Services – Hospital Services – Inpatient Psychiatric Services
- Chapters 388-865, 388-877, 388-877A WAC – Department of Social and Health Services – Mental Health – Community Mental Health and Involuntary Treatment Programs
- Chapter 71.05 RCW – Mental Illness – Mental Illness
- Chapter 71.24 RCW – Mental Illness – Community Mental Health Services Act
- Chapter 71.34 RCW – Mental Illness – Mental Health Services for Minors
- Inpatient Hospital Provider Guide, July 2014 or its successors

Other

- The Department of Social and Health Services RSN Interlocal Agreement State Mental Health Contract and any subsequent amendments
- The Department of Social and Health Services RSN Interlocal Agreement Prepaid Inpatient Health Plan and any subsequent amendments
- Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR), or its successor
- International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), Sixth Edition, or its successor

WHICH RSN SHOULD A HOSPITAL CALL FOR AUTHORIZATION?



AUTHORIZATION LOG
Date: ____ / ____ / ____

Patient Name	Date of Birth	Admit Date	Hospital	ProviderOne ID	ProviderOne Auth #	# of Days Authorized	Date of Last Authorized Day

King County Mental Health Plan
Notification of Medicare or Commercial Insurance

Last Name:	**First Name:**	
Medicaid ID (PIC):	**KCID (if known):**	
DOB:	**SSN:**	**Gender:**
Date of Admission:	**Hospital:**	
Diagnosis Code(s):		

The above person has (circle one):

Medicaid coverage and Medicare, with benefits that are not exhausted.

Medicaid coverage (but Medicaid will not be paying a copay) and commercial insurance (specify)_____, with benefits that are not exhausted.

Hospital representative signature:	**Telephone:**	**Date:**

For persons who have both Medicaid and Medicare coverage (that is not exhausted) at the time of the admission, the hospital must inform the care authorizer that the admission is occurring but need not seek authorization.

For persons who have Medicaid and Medicare coverage (but it is exhausted at the time of the admission), the hospital must seek authorization for the admission as it would for a person who had only Medicaid.

For persons who have Medicaid and Medicare coverage, where the Medicare coverage becomes exhausted during the course of an admission, the hospital must seek authorization no later than the calendar day of the benefit exhaustion. The KCMHP care authorizer will respond to the request within two hours and make an authorization decision within 12 hours.

When a hospital is unclear about the exhaustion of a person's Medicare coverage and the person has Medicaid, the hospital may seek an authorization prior to the admission or within the first 24 hours of the stay. When such requests are received by a specialty psychiatric hospital, the care authorizer may suggest the client be admitted to a general hospital psychiatric unit, if this will extend the Medicare coverage.

For persons who have both Medicaid and unexhausted private coverage at the time of the admission, the hospital must seek authorization, if Medicaid will be paying a copay, or inform the care authorizer that the admission is occurring, if Medicaid will not be paying a copay.

If Medicaid has not been paying a copay and the private coverage becomes exhausted during the admission, the hospital must seek authorization no later than the calendar day of the benefit exhaustion. The KCMHP care authorizer will respond to the request within two hours and make an authorization decision within 12 hours.

****To seek authorization, the hospital should call the KCMHP care authorizer at 206-461-4858 or 1-866-461-3222.***

Fax this completed form to Crisis Clinic Hospital Authorization: 206-436-2970

King County Mental Health Plan
Notification of Change in Legal Status

Last Name:	**First Name:**
Hospital:	**KCID (if known):**
DOB:	**SSN:**
Date of Admission:	**Date of Change in Legal Status:**
Does this person have Medicare?	

The above person had the following legal status change on the date above (check one):

- o **Voluntary to involuntary**
- o **Involuntary to voluntary**

Hospital representative signature:	**Telephone:**	**Date:**

King County Mental Health Plan Policy and Procedures Manual regarding persons who change legal status

When a client changes from involuntary to voluntary or from voluntary to involuntary, the hospital must notify the care authorizer by the next business day. For this notification, hospitals should use Attachment D: Form for Change in Legal Status.

Days authorized at the time of a legal status change (from involuntary to voluntary or from voluntary to involuntary) will not be rescinded.

Fax this completed form to Crisis Clinic Hospital Authorization: 1-206-436-2970

PATIENT PLACEMENT DECISION TREE: ADULTS

Current Providers of Adult Involuntary Inpatient Services for King County:

Harborview Medical Center (HMC)	325 Ninth Ave	206-731-3074
Navos Inpatient Services (NIS)	2600 SW Holden St.	206-933-7299
Northwest Hospital Geropsychiatric Center (NWGP)	1550 N 115th St.	206-368-1823
Fairfax Hospital (FFX)	10200 NE 132nd, Kirkland	425-821-2000
Western State Hospital (WSH)	9601 Steilacoom Blvd SW, Lakewood	253-582-8900

It is assumed that before a patient is detained and a referral to an evaluation and treatment facility (E&T) is made, all less-restrictive alternatives to detention have been ruled out (with the exception of referrals made by courts pursuant to Revised Code of Washington 10.77.090 or its successor). This includes consultation with case managers (in cases where the person is enrolled in the public mental health system); consultation with geriatric, children's and minority specialists; crisis/respite care and hospital diversion beds; voluntary hospitalization; and other alternatives to detention as appropriate to the individual situation.

The Crisis and Commitment Services Policy and Procedures provides guidelines for medical screening of detained persons (Sections 1.3.22a and 1.3.22b). If you did not have the person screened at an emergency room, you must still make certain that you tell the admitting E&T about any known medical problems. You must document to whom you spoke and what information you provided.

DECISION TREE

1. Refer all patients ages 18 and above to Navos Inpatient Services (NIS), except for those specified below. When referring a patient to NIS they will be using a medical screening form to identify any medical problems. The NIS screening nurse will ask the ER physician diagnosing or treating the patient to respond to the screening form questions. Depending on the medical screening results provided by the ER, the screening nurse may be required to consult by phone with the Navos Inpatient on-call psychiatrist to confirm the admission.

   NIS cannot take patients who:
   - Have physical care needs that require inpatient medical treatment;
   - Have IVs;
   - Require tube feedings;
   - High-risk pregnancy; or
   - Are wheelchair-dependent and CANNOT transfer from chair to bed by themselves.

2. If NIS is full or unable to accept the patient, refer to Harborview (HMC) or Fairfax (FFX). When making a referral, you must establish the county of residence of the individual being detained and notify the hospital screener.

3. Refer the following patients first to HMC. If HMC is full or does not accept the patient, then refer to NIS.
   - Patient has demonstrated violent or assaultive behavior immediately preceding or during the DMHP evaluation, or is out of control in the field.
   - Patient is experiencing a sudden onset psychosis, or serious unexplained deterioration in functioning.
   - Patient is under 60 years old and is suffering from cognitive or memory impairment with no previous workup.
   - Patient has a medical condition requiring treatment in a medical inpatient hospital or extensive diagnostic procedures. If the patient has a current medical problem that requires evaluation, the nearest ER will evaluate. If medically cleared by an Emergency Department (ED), the patient may be detained to an E&T.

4. Refer all individuals age 60 and older to Northwest Geropsychiatric Inpatient Center (NWGP), or NIS, except as noted above. If NIS and NWGP are full or cannot accept the patient, refer to HMC. If unable to place the patient at NIS, HMC, NGP or FFX, consider a one-bed certification.

5. Out-of-county placement is best reserved for residents of other counties (e.g., Stevens Hospital or Snohomish County E&T for Snohomish County residents, Skagit County E&T for North Sound residents, and Pierce County RTF for Pierce County residents). The geriatric mental health unit at Valley General in Monroe is an E&T and is an option for geriatric patients if local placement is impossible. There may be some circumstances that warrant placement of a King County resident in other counties. Consult with the supervisor.

6. Fairfax, HMC, NIS and NWGP are all preferred providers for adult Group Health patients needing inpatient mental health care. Detained Geriatric Group Health patients should be referred to NWGP first. These hospitals may be preferred providers for other insurance patients as well.

7. When all units are full or patient is not accepted anywhere, refer to Western State Hospital (WSH).
    - When referring a patient with an identified medical problem to WSH, the DMHP should have the treating or diagnosing ER physician speak directly to the WSH admitting nurse or physician to clarify any questions about the patient's medical condition and needed treatment.
    - If WSH refuses to accept the patient, ask for a single-bed certification and follow that procedure.

PATIENT PLACEMENT TREE: JUVENILES

Current Certified Evaluation and Treatment Providers of Juvenile Involuntary Inpatient Services for King County:

Fairfax Hospital (FFX) ..... 10200 NE 132nd, Kirkland 425-821-2000

Navos Inpatient Services (NIS) ..... 2600 SW Holden, Seattle 206-933-7299

There have been many changes in hospital practice that have restricted juvenile admissions over the last few years. At a minimum, consultation from a child mental health specialist is required. When minors are placed on an adult unit, they must be kept safe and separate, which usually means obtaining a private room. This makes placement more difficult. Our contract with NIS requires them to accept juveniles we refer when those conditions can be met. Harborview (HMC), University of Washington (UW) and Stevens Hospitals will no longer accept juvenile admissions.

The following is our current procedure for placement of juveniles:

1. Fairfax Hospital (FFX) is the primary resource for our ITA treatment system for juveniles. Refer all juveniles 13-17, from any county, to FFX first (425-821-2000). Exceptions would be someone already at McGraw Center or Children's as a voluntary whom you detain to that facility, or an adolescent who needs intensive medical care.

   If the FFX screener initially refuses to accept the juvenile due to capacity or milieu issues, or for any other reasons, ask to speak to the on-call administrator to make certain that FFX will not be able to admit the juvenile before proceeding with the other options below.

2. If a bed at FFX is not available and the juvenile is a King County resident:
   - If the juvenile is 15-17 years of age, refer first to NIS.
   - If the juvenile is 13-14 years of age, refer first to Children's Hospital (206-987-2055). Children's Hospital requires a one-bed certification. If Children's is full or unable to admit the juvenile, refer to NIS.

3. If a bed at FFX is not available and the juvenile is an out-of-county resident:
   - Refer to the E&T resources in or near the county of residence.
   - If FFX and out-of-county facilities are not available for the out-of-county juvenile, and the juvenile is 15-17 years of age, refer to NIS.

4. If no beds are available in King County, you may call out-of-county evaluation and treatment facilities:

   Lourdes Counseling Center: 509-547-7704

   Sacred Heart Medical Center: 509-474-3213

   Before making a decision to send the patient across the state, consider factors such as when a bed may open up locally and how difficult the transport might be for the patient.

5. If no beds are available anywhere in the state, and all alternatives to hospitalization have been explored, detain the juvenile to the referring E.D. until a more appropriate bed is open. Do not send a patient to the HMC PES from elsewhere without consulting a supervisor. For those in the PES, notify Ed Dwyer-O'Connor via pager 206-680-8012.

EXTENSION REQUEST FOR HOSPITALIZATION
KING COUNTY MENTAL HEALTH PLAN

Client Name:		Birth Date:
Inpatient Facility:		
Date of Admission/Detention:		
Principal Diagnosis:		
Other Diagnoses/Medical Co-Morbidity:		
Extension Request:	First ☐ Second ☐ Third ☐ Fourth ☐ Fifth ☐ Sixth ☐	

Current Symptoms/Level of functioning:	
Medication adjustments/effectiveness:	
Support Network Issues/Discharge Plan:	
Number of Extension Days Requested:	days through:

Hospital Reviewer Signature:_____ Date: _____

Send to Crisis Clinic 206-436-2970 (FAX)

FOR KING COUNTY REGIONAL SUPPORT NETWORK USE ONLY

Number of Extension Days Approved: _____ days through _____
Number of Administrative Days Approved: _____ days through _____
Number of Extension Days Denied: _____ days through _____
Authorizing Signature of KCRSN:

_____ Date: _____

Signature of MD (for children under 18 and all denials):

_____ Date: _____

Comments: _____

_____

_____

King County RSN: Patient Information for IP Psychiatric Hospitalization

Admit (optional request for ITA with no current coverage) ☐ **Discharge** ☐

	Hospital:	***NPI:***	***Date:***

	Name	DOB	P1 Client ID	ITA/VOL	P1 Auth #	Dates of Service	# of days	D/C dx
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								

King County

NOTICE OF ACTION ABOUT YOUR MENTAL HEALTH SERVICES

Date:

To:

From: Client Services
King County Mental Health Plan (KCMHP)
Chinook Building
401 Fifth Avenue, Suite 400
Seattle, WA 98104-1598

This is to let you know about an action we are planning to take concerning your Medicaid-funded mental health services that you requested or are currently receiving.

We have decided your inpatient treatment will be:

- ☐ **DENIED** Effective Date
- ☐ **DENIED PAYMENT**

The reason for this decision is:

- ☐ There are available outpatient services that meet your needs.
- ☐ Treatment of your condition does not require physician-directed inpatient services.
- ☐ Inpatient services are not likely to improve your condition or prevent further deterioration so that services will no longer be needed.
- ☐ You do not have a mental disorder covered for inpatient care.

However, you are entitled to a second opinion.

IF YOU DON'T AGREE WITH THIS DECISION, you have the right to appeal. If you choose this right, you have twenty[1] (20) calendar days from the date this notice was mailed to request or file an appeal. Your mental health provider may also file an appeal on your behalf when you ask them in writing. To request or file an appeal, you need to contact: KCMHP Client Services by calling 1-800-790-8049 or send your appeal to the address above or by fax to 206-205-1634.

If YOU NEED HELP WITH FILING AN APPEAL you may contact the KCMHP Ombuds Service at 1-800-790-8049. The Ombuds Service is available at no charge to assist you or your representative throughout the appeal process. If you are hard of hearing or deaf, or have trouble with speech, please contact us through the Telecommunication Relay Service at 1-800-833-6384 or dial 711. The Relay Service will be able to provide you with the correct phone number. If you need interpreter services they will be provided to you.

You may also have other persons of your choice assist you during the appeal process. If you want someone else to assist you, you and your authorized representative must sign, date, and send us a statement naming that person to act for you.

Before you file an appeal, please see "Important Information About Your Appeal Rights" on the next page

[1] If you want to continue to receive your current services during the appeal process, you must file your request within ten (10) calendar days of the receipt of this notice of action.

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

Definitions

Denial: The decision not to offer an intake is a denial. The decision by a PIHP, or their formal designee, not to authorize covered Medicaid mental health services that meet medical necessity is a denial.

Suspension: The decision by a PIHP, or their formal designee, to temporarily stop your previously authorized covered Medicaid mental health services described in their Level of Care Guidelines. The decision by a Community Mental Health Agency to temporarily stop or change a covered service in the Individual Service Plan is not a suspension.

Reduction: The decision by a PIHP to decrease your previously authorized covered Medicaid mental health services described in their Level of Care Guidelines. The decision by a Community Mental Health Agency to decrease or change a covered service in the Individual Service Plan is not a reduction.

Termination: The decision by a PIHP, or their formal designee, to stop your previously authorized covered Medicaid mental health services described in their Level of Care Guidelines. The decision by a Community Mental Health Agency to stop or change a covered service in the Individual Service Plan is not a termination.

There Are Two Kinds of Appeals You Can File

Standard (45 days) You or your mental health care provider acting on your behalf can ask for a standard appeal. We must give you a decision no later than 45 days after we get your appeal. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)

Expedited (Fast, 3 working days) You or your mental health care provider can ask for a fast appeal if you or your mental health care provider believe that your life, health or major ability to function could be seriously harmed by waiting for a standard appeal. We must decide your appeal no later than 3 working days after we get your appeal. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)

- If your mental health care provider asks for an expedited appeal for you, or supports you in asking for one, and they indicate that waiting 45 days could seriously harm your health, we will automatically give you a fast appeal.
- If you ask for an expedited appeal without support from your mental health care provider, we will decide if your health requires one. If we do not agree with you, we will decide your appeal within 45 days.

How Do I File An Appeal?

For a Standard Appeal: You, your mental health provider, authorized representative, or an Ombuds should mail or deliver your written appeal to the address below. You may file verbally but, it must be followed in writing.

For a Fast Appeal: You, your mental health provider, authorized representative, or an Ombuds should contact us by telephone or fax at the numbers listed below.

Can I Continue to Receive Services?
If you are currently receiving services, your services will be continued during the appeal process when:

- Your appeal is filed within 10 days from KCMHP mailed date.
- Your appeal involves the reduction, suspension or termination of previously authorized covered Medicaid mental health services;
- The current period covered by the authorization has not expired, and the Notice of Action was mailed to you timely;
- You have requested an extension.

If our decision is not your favor, you may be asked to pay for the services you received during the appeal or hearing.

What Do I Include With My Appeal?
You should include: your name, address, reasons for appealing, and any evidence you wish to attach. You may send in supporting records, letters from your mental health provider, a list identifying qualified witnesses, or other information that explains why we should provide the service. Call your mental health provider if you need this information to help you with your appeal.

You may send this information to KCMHP or present this information in person.

What Happens After I File An Appeal? People from KCMHP who were not involved in the decision review your appeal and provide a written decision within 45 days unless an extension has been requested.

What Happens Next? After KCMHP makes a decision about your appeal and you do not agree with the KCMHP decision, you may ask for a fair hearing through the State Office of Administrative Hearings (1-800-583-8271). You must request a fair hearing within 20 days after you receive the KCMHP decision. You may also access a fair hearing if:

- KCMHP does not provide a written response within the allowed time frames; or
- You believe there has been a violation of WA State Department of Social and Health Services rules.

Your services may be continued during the Administrative Hearing Process.

Contact Information: If you need information or help, call us at:
Client Services
King County Mental Health Plan (KCMHP)
The Chinook Building
401 Fifth Avenue, Suite 400
Seattle, WA 98104-2333
Telephone: 1-800-790-8049 or Fax: 206-205-1634

Hearing or Speech Impaired, please contact us via:
Telecommunication Relay Service at
1-800-833-6384 or dial 711

Other Resources to Help You:
King County Mental Health Plan Ombuds Service
Telephone: 1-800-790-8049 or Fax: 206-296-1438

WA State Department of Social and Health Services Office of Administrative Hearings
P. O. Box 42488
Olympia, WA 98504-2488
1-800-583-8271

King County

NOTICE OF DETERMINATION ABOUT YOUR MENTAL HEALTH SERVICES

Date:

To:
Name and Address of Non-Medicaid Client / Representative (if relevant)

From: Client Services
King County Mental Health Plan (KCMHP)
Chinook Building
401 Fifth Avenue, Suite 400
Seattle, WA 98104

This is to let you know about a determination we have made concerning your state-funded mental health services that you requested or are currently receiving.

We have decided that your voluntary inpatient treatment will be:

☐ **DENIED** Effective Date _____

The reason for our decision is:

- ☐ There are available outpatient services that meet your needs.
- ☐ Treatment of your condition does not require physician-directed inpatient services.
- ☐ Inpatient services are not likely to improve your condition or prevent further deterioration so that services will no longer be needed.
- ☐ You do not have a mental disorder covered for inpatient care.

IF YOU DON'T AGREE WITH THIS DECISION, you may file a grievance. To request or file a grievance, you need to contact:

KCMHP Client Services
Call 1-800-790-8049
Or, send your request for a grievance to the address above or by fax to 206-205-1634

If YOU NEED HELP WITH FILING A GRIEVANCE you may contact the KCMHP Ombuds Service at 1-800-790-8049. The Ombuds Service is available at no charge to assist you or your representative throughout the grievance process. If you are hard of hearing or deaf, or have trouble with speech, please contact us through the Telecommunication Relay Service at 1-800-833-6384 or dial 711. The Relay Service will be able to provide you with the correct phone number. If you need interpreter services they will be provided to you.

You may also have other persons of your choice assist you during the grievance process. If you want someone else to assist you, you and your authorized representative must sign, date, and send us a statement naming that person to act for you.

IX. ADDITIONAL OUTPATIENT SERVICES

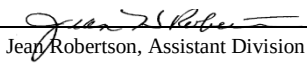
1.0 POLICY TITLE: ADDITIONAL OUTPATIENT SERVICES

1.1 Originally Implemented: April 1, 1995

1.2 Reviewed and revised: November 2014

1.3 Officially Adopted: January 2, 2015

1.4 Effective Date: February 2, 2015

1.5 Signed: 

Jean Robertson, Assistant Division Director/RSN Administrator

2.0 PURPOSE: to briefly describe the outpatient mental health services to be provided through carve-out programs. These services will be provided through provider contracts managed by the King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD).

3.0 POLICY/PROCEDURE/RESPONSIBILITIES:

3.1 Clubhouse Services

3.1.1 Program

A. A program certified by International Center for Clubhouse Development that provides a community intentionally organized to support individuals living with the effects of mental illness.

B. Through participation in a Clubhouse, members are given the opportunities to rejoin the worlds of friendships, family, important work, employment, and education, and to access the services and supports they may individually need.

C. A Clubhouse is a restorative environment for people who have had their lives drastically disrupted and need the support of others who believe that recovery from mental illness is possible for all.

3.1.2 Eligibility

Persons who are participants in the King County Mental Health Plan and who are at least 18 years of age, , are receiving outpatient and/or residential services and clubhouse services are requested by the individual. The Clubhouse shall make efforts to provide services within the context of ongoing collaboration with the outpatient and/or residential treatment provider.

3.2 Crisis Diversion Facility

3.2.1 Program

A. The Crisis Diversion Facility (CDF) is a 16-bed facility that accepts individuals in crisis 24 hours a day, 7 days a week.

B. Services include evaluation, crisis and stabilization services, case management, needs assessments, mental health and substance use disorder services, medication management, nursing services, peer support, and linkage with community-based services.

C. Individuals may stay as needed, up to 72 hours.

3.2.2 Eligibility

Persons served need be:

A. Age 18 and over;

B. In mental health and/or substance use crisis in King County (need not be King County residents);

C. Referred by King County first responders, including law enforcement, hospital ED social worker, designated mental health professional, fire departments/ Medic One, or the Mobile Crisis Team.

D. Agreeable to receiving services; and

E. In behavioral control, not deemed an imminent danger to self or others, nor likely to require seclusion or restraint to maintain safety.

3.3 Crisis Diversion Interim Services

3.3.1 Program

A. The Crisis Diversion Interim Services program provides interim “respite” housing for individuals ready to leave the CDF, but may need additional supports and services prior to discharge.

B. Is co-located with the CDF.

C. Persons can stay up to two weeks.

D. Services at the CDIS include counseling and peer support, medication management, nursing services, case management focusing on coordination and linkage with needed community services and supports, review and assessment of housing options and placement assistance at discharge.

3.3.2 Eligibility

Individuals who are referred from the CDF:

A. Who are homeless or at risk for homelessness;

B. Whose current living situation has the potential to send the individual into crisis again; or

C. Whose immediate needs may take longer to address after the initial behavioral crisis has resolved.

3.4 Crisis Team (Mobile)

3.4.1 Program

A. The Mobile Crisis Team (MCT) intervenes with individuals in behavioral health crisis 24 hours a day, 7 days a week in their own communities to identify immediate resources and relieve the need for any further intervention.

B. When available, the team may transport persons in crisis to the CDF.

C. When available, the team will also assist with transportation of persons out of the CDF to the community.

D. Services provided by the MCT will include crisis phone triage, crisis intervention and stabilization, development of resource and referral plans, and/or safety plans as appropriate, as well as referral and linkage to necessary social and healthcare services.

3.4.2 Eligibility

Persons served need to be:

A. Age 18 and over;

B. In mental health and/or substance use crisis in King County (need not be King County residents); and

C. Referred by King County first responders including law enforcement, hospital ED social worker, designated mental health professional and fire departments/Medic One.

3.5 Crisis Respite Program at Downtown Emergency Service Center (DESC)

3.5.1 Program

A. The Crisis Respite Program (CRP) at DESC provides shelter/residential services, access to and services of a psychiatric specialist ARNP, case management services, and assistance with linkages to more permanent housing and treatment services.

B. There are 20 crisis respite beds and accompanying transitional case management services for adults from eligible referral sources.

3.5.2 Eligibility

Persons age 18 years or older referred by one of the following sources. Referrals are prioritized as follows:

A. Harborview Medical Center (HMC) Psychiatric Emergency Service (PES);

B. Any hospital emergency room within King County;

C. King County Crisis and Commitment Services (CCS);

D. Mental Health Court, Seattle Municipal Court, or King County District Court;

E. HMC psychiatric inpatient services;

F. Navos inpatient services;

G. Recovery Centers of King County (RCKC) Detox; and

H. Adult inpatient and residential liaisons.

3.6 Expanding Community Services (ECS)/Community Support and Recovery Services

3.6.1 Program

A. A high-intensity service program that provides residential treatment and housing supports for individuals transitioning from Western State Hospital (WSH) to the community and into independent living settings.

B. The program provides on-site staffing up to 12 hours a day 7 days per week and access to staff 24 hours a day.

3.6.2 Eligibility

Individuals who have been in hospital care at WSH for at least one year continuously and require high-intensity services to maintain community tenure.

3.7 Forensic Assertive Community Treatment (FACT)

3.7.1 Program

A. FACT consists of the evidence-based practice, Assertive Community Treatment (ACT), which consists of a service-intense, outpatient treatment model that provides 24/7, time-unlimited support to participants who are eligible.

B. FACT is adapted for individuals with a history of criminal justice involvement, has a goal of preventing future criminal justice involvement, and provides permanent supportive housing and reentry coordination directly from incarceration.

C. FACT is a self-contained transdisciplinary team of staff from multiple disciplines (mental health professional, chemical dependency specialist, nurse, psychiatrist, vocational specialist, peer specialist, and boundary spanner) who work together to provide recovery-oriented, wraparound services.

D. The team works seven days a week and is available 24 hours a day to provide after-hours crisis response to enrolled participants.

3.7.2 Eligibility

A. Diagnosed with a severe and persistent mental illness, and

B. Have become repeatedly involved in the criminal justice system with a minimum of five bookings in the past 12 months in jail in King County.

3.8 Forensic Intensive Supportive Housing (FISH)

3.8.1 Program

A. The FISH program is a seven-day-a-week program offering the dual approach of housing first and intensive treatment, including assertive outreach and engagement.

B. The program begins with offering supportive housing in a housing-first approach to eligible individuals. While housing needs are addressed, the FISH team works to provide effective prevention and intervention strategies and treatment for those most at risk and most in need to reduce or prevent more acute illness, high-risk behaviors, incarceration, and other emergency medical or crisis responses.

C. Services include evidence-based Integrated Dual Disorders Treatment (IDDT), time-unlimited services provided from a recovery and resiliency perspective, vocational training to help participants find and keep jobs, and 24-hour crisis services.

3.8.2 Eligibility

A. Homeless adults who have been seen by the King County District Court Mental Health Court (MHC), the City of Seattle Municipal MHC or the City of Auburn MHC who are unable to participate in a MHC because they have been found to be not legally competent and a dismiss and detain order has been entered by the court; or

B. Homeless adult U.S. military veterans with any Axis 1 mental health disorder or co-occurring mental health and substance use disorders in a King County jail or municipal jail within King County identified by the Washington State Department of Veterans Affairs (WDVA) to qualify for services under the eligibility criteria set forth by the King County Veterans Levy Program.

3.9 Geriatric Regional Assessment Team (GRAT)

3.9.1 Program

Countywide comprehensive outreach services for older adults provided in the community, including:

A. Comprehensive mental, medical, social, and functional assessments;

B. Referral and linkages to mental health, aging, and health care providers;

C. Consultation, care planning, and education for families or other care providers, mental health providers, aging services providers, and health care providers;

D. Coordination of after-hours crisis services with the Department of Developmental Disabilities (DDD) special crisis program; and

E. Telephone consultation for the Crisis Clinic and DMHPs.

3.9.2 Eligibility

Adults 60 years old or older with complex needs requiring specialized crisis services who are not enrolled in the KCMHP and are not residing in a nursing home.

3.10 Housing Access Services Program (HASP)

3.10.1 Program

HASP makes King County Housing Authority (KCHA) Section 8 vouchers available to selected mental health providers for their enrolled clients. Providers assist the client in the referral and housing search process. Providers must provide support services at the housing site as needed and crisis/stabilization services when issues arise that jeopardize the client's housing stability.

3.10.2 Eligibility

Persons who are participants in the King County Mental Health Plan and who are at least 18 years of age, are disabled, low-income, and meet the Federal preferences established by Housing and Urban Development (HUD) and the local preferences established by KCHA.

3.11 Homeless Outreach Stabilization and Transition (HOST)

3.11.1 Program

A. The HOST Project is an outreach and engagement, intensive stabilization, and reengagement program for persons with mental illness who are homeless.

B. The goal is to transition clients from the HOST program to authorized services with KCMHP providers.

3.11.2 Eligibility

A. An individual meeting all of the following criteria is eligible to participate in the HOST Project:

1. The person must be at least 18 years of age;

2. The person must be homeless;

3. The person appears to have a serious and persistent mental illness; and

4. The person is unable or unwilling to access services through the KCMHP due to clinical reasons.

B. An individual who is at least 18 years of age and homeless and is currently authorized to a KCMHP outpatient case rate benefit but has not received services for 90 or more days.

3.11.3 Service coordination

A. The KCMHP will support the work of the HOST Project to transition clients to an outpatient level of care or LTR.

B. For purposes of transitioning HOST clients to an outpatient level of care or to LTR, a client may receive services from both the HOST provider and the outpatient service provider or LTR provider for up to 45 days. After that time, it is expected that the provider holding level of care authorization will be the sole service provider.

C. Transition services exceeding the 45-day period will be monitored by KCMHP.

D. When clients authorized to receive services through the HOST provider seek services at another provider and a simultaneous authorization is identified, it is the responsibility of the provider who wishes to seek authorization for the client to contact the HOST provider prior to delivering services and negotiate:

1. Transition to the new provider, and

2. A consultation as per Section VI: Outpatient Services Level of Care, and

3. Referral of the client back to the HOST provider, and/or

4. Referral of the client to the HOST's crisis subcontractor.

E. For clients who are authorized to an outpatient level of care with a provider and who seek services at the HOST provider, it is the responsibility of the HOST provider to identify a simultaneous authorization, contact the other provider prior to delivering services, and negotiate to provide services to facilitate re-engagement of the client with the original provider.

F. For clients who are authorized to an outpatient level of care and who seek to transfer to the HOST provider, the provider change "for cause" explained in Section VI: Outpatient Services Level of Care will apply.

G. For clients who are identified by HOST staff as being currently authorized to an outpatient level of care with a provider but have not received services from that provider for a minimum of 90 days, HOST staff will contact the outpatient provider to reengage the client in services. If the reengagement efforts are unsuccessful but the client is willing to receive outpatient level of care, the provider change "for cause" explained in Section VI: Outpatient Services Level of Care will apply.

H. Clients who are part of the HOST program will not be authorized to an outpatient level of care.

3.12 Integrated Dual Disorders Treatment (IDDT)

3.12.1 Program

A. IDDT includes a recovery-oriented, evidence-based practice for eligible participants with co-occurring Axis I mental health and substance use disorders in a team-based approach. Services are provided in a full, coordinated approach addressing both mental health and substance issues.

B. The IDDT program is an 18-month benefit providing housing, mental health and substance use disorder treatment, assertive outreach and engagement, motivational interviewing, and Moral Reconation Therapy (MRT), an evidence-based treatment for individuals with criminal justice involvement.

C. Services provided are multi-disciplinary and include coordination with the criminal justice entity with which participants are involved (i.e., Mental Health Court, Drug Court, or King County jails).

3.12.2 Eligibility

A. Clients must have a co-occurring Axis I major mental disorder and active substance use disorder that is ongoing; and

B. Clients are referred by the Seattle Municipal Mental Health Court or the King County Regional Mental Health Court liaisons, or the King County Adult Drug Diversion Court counselors; or

C. Clients are referred by a Jail Health Services release planner sited at the King County Correctional Facility or the Maleng Regional Justice Center and have a history of two or more incarcerations in a jail within King County; or

D. Clients are referred by a criminal justice liaison from a municipal jail in South or East King County and have a history of two or more incarcerations in a jail within King County.

3.13 Liaisons

3.13.1 Adult Criminal Justice Liaisons

Role and Function

A. King County adult criminal justice system liaisons serve as points of contact for KCMHP providers serving adults who have been released from incarceration into the community and are sited at the following locations:

1. South and East King County;

2. King County Community Center for Alternative Programs (CCAP); and

3. King County Work and Education Release (WER).

B. Providers shall develop internal policies and procedures that connect eligible adults referred by liaisons to outpatient mental health services.

3.13.2 Children's Criminal Justice Liaisons

Role and Function

A. King County children's justice system liaisons serve as points of contact for KCMHP providers with the King County Juvenile Court and King County Juvenile Detention.

B. Providers shall develop internal policies and procedures that connect eligible children and youth referred by liaisons to outpatient mental health services.

C. Providers shall respond to referrals by the children's justice system liaisons.

D. For clients authorized for an outpatient level of care: providers will be notified when a client has been or is involved with the King County juvenile justice system.

E. For unenrolled individuals preliminarily screened for eligibility in the KCMHP per the non-Medicaid criteria in Section VI Outpatient Services Level of Care, providers shall make every effort to set intake appointments before the child is released.

3.13.3 Adult Inpatient and Residential Liaisons

Role and Function

A. Provide discharge planning for King County residents who are receiving:

1. Inpatient services level of care at:

a. Western State Hospital (including the Center for Forensic Services);

b. Community hospitals; and

c. Evaluation and treatment facilities, or

2. KCMHP residential treatment services or supportive housing.

B. The liaisons function as part of the treatment team and perform the residential level of care assessment to determine placement eligibility for LTR, Supervised Living (SL), Standardized Supportive Housing (SSH), and Midway programs.

C. The liaison also makes referrals to KCMHP providers for outpatient level of care, as well as referrals to PACT and ECS programing.

D. See Section VII, Residential Services Level of Care and Section VIII, Inpatient Services Level of Care.

3.14 Medicaid Personal Care (MPC)

3.14.1 Program

A. The purpose of Medicaid Personal Care services is to provide a Medicaid client with semi-skilled maintenance and supportive assistance so he/she may remain living in the community.

B. The Washington State Aging and Adult Services Administration (AASA) and the Division of Developmental Disabilities (DDD) are responsible for their respective consumers who require MPC for a physical disability, regardless of whether they also have a psychiatric need or are authorized for KCMHP outpatient services.

1. All referrals for MPC are made to Washington State Home and Community Services (HCS).

2. HCS screens the referrals and submits appropriate requests to KCMHP clinical staff for authorization of payment.

3. When KCMHP clinical staff receives a request from HCS, KCMHP clinical staff may contact the client's outpatient mental health treatment provider to obtain information on the following:

   a. The relationship between the mental illness or psychiatric disability and the need for MPC;

   b. The potential for treatment to increase the client's functioning so that MPC services may no longer be needed in the future; and

   c. In those instances when treatment might improve such functioning, that the current Individual Service Plan (ISP) is also addressing this need.

4. If the request is for services that are covered as part of the state mental health plan Title XIX service modalities, KCMHP clinical staff will recommend that the outpatient mental health treatment provider assume the responsibility for those services and will notify HCS about the recommendation.

5. KCMHP shall respond to a request for MPC services within five days of receipt of a complete request from HCS.

6. MPC services will not be authorized retrospectively.

7. Changes in the MPC treatment plan or changes in the use of approved funds must be requested in writing following the procedures outlined above.

8. Past exceptions to policy either regarding particular client profiles or clinical scenarios do not set precedent for future expenditure or mandate the use of funds in any way.

9. See Section IV, Financial Management for payment procedures.

3.14.2 Eligibility

KCMHP is responsible for authorizing payment for MPC services for clients who meet the following criteria:

A. The client has a current KCMHP outpatient authorization;

B. These services are needed solely due to the client's mental illness(es); and

C. These services are not needed due to a physical or developmental disorder.

3.15 Mental Health Court

3.15.1 Program

A. The King County Mental Health Court liaison serves as the primary point of contact between the Mental Health Court and the KCMHP providers.

B. Providers shall have internal policies and procedures to connect eligible persons referred by the Court to outpatient mental health services.

3.15.2 Eligibility

A. Providers shall respond to referrals by the Mental Health Court.

B. For clients authorized to the outpatient level of care: The assigned provider staff shall be the primary point of contact between the Mental Health Court liaisons, criminal justice system liaisons, and/or King County Correctional Facility Psychiatric Evaluation Services Staff (PES). The assigned provider's telephone response time should not exceed three hours.

C. For individuals not authorized to an outpatient level of care but preliminarily screened for eligibility in the KCMHP per the non-Medicaid criteria in Section VI, Outpatient Services Level of Care, providers shall make every effort to set an intake appointment before the client is released from custody.

D. For individuals not authorized to an outpatient level of care but who are Medicaid recipients with a King County Community Service Office (CSO) or other KCMHP-qualifying CSO: Each KCMHP provider shall identify a clinical staff person to work with the Mental Health Court liaisons. Response to the Mental Health Court liaison shall not exceed one business day. The clinical staff person shall, upon the request of the Mental Health Court liaison:

1. Complete a formal intake and assessment to determine eligibility for KCMHP outpatient level of care; and

2. Provide linkage to mental health services including ISP development and ongoing treatment and ancillary support services.

E. Each provider of services to a referred, eligible individual shall prepare a comprehensive ISP that includes court-ordered services. The provider shall submit this plan to the Mental Health Court liaison for review. Subsequent to Mental Health Court liaison satisfactory review, the provider shall collaborate with the Mental Health Court liaison and other appropriate staff to secure the necessary treatment resources. The clinical staff assigned to each Mental Health Court client shall provide

consultation to the Mental Health Court liaison or Mental Health Court judge as necessary and shall accompany the client to required court appearances.

F. KCMHP providers are responsible for reporting treatment compliance directly to the court liaisons for individuals who have been place on judicial review. The court liaisons will supply providers with a compliance-monitoring template for treatment compliance status reporting to the court.

3.16 Mentally Ill Offenders

3.16.1 Forensic Integrated Re-entry Support and Treatment (FIRST), formerly Mentally Ill Offender Community Transition Program (MIO-CTP)

A. Program

1. FIRST is an intensive service program for persons with mental illness being released from a State Department of Corrections (DOC) prison or work release facility.

2. The goal is to transition clients from the intensive FIRST services to standard outpatient services. Clients in this program must meet state Access to Care diagnostic criteria (see Section VI: Outpatient Services Level of Care).

B. Eligibility

1. Adult persons referred by the state DOC from a three facility as defined by State Legislature and selected by the Community Review Team.

2. On a limited and exception to policy basis, direct referrals may be made by MHCADSD.

C. Transitioning from FIRST to outpatient or LTR level of care

1. For purposes of transitioning clients from FIRST to outpatient or residential level of care, a client may receive services from both the FIRST provider and the outpatient services provider or LTR provider for up to 45 days. After that time, it is expected that the provider holding the level of care authorization will be the sole service provider.

2. Transition services exceeding 45 days shall be monitored by KCMHP.

D. Changing providers

When clients who are authorized to receive services through the FIRST provider seek services at another provider and a simultaneous authorization is identified, it is the responsibility of the provider who wishes to seek authorization for the client to contact the FIRST provider prior to delivering services in order to negotiate:

1. Transition to the new provider;

2. Services provided by a licensed subcontractor as per Section VI Outpatient Services Level of Care;

3. Referral of the client back to the FIRST provider; and

4. Referral of the client to the FIRST crisis services.

3.16.2 Offender Re-Entry Community Support Program (ORCSP), formerly Community Integration Assistance Program (CIAP) and formerly Dangerously Mentally Ill Offender (DMIO)

A. Program

1. ORCSP is an intensive case management services program for adult persons who are deemed dangerous and mentally ill and are being released from a DOC facility.

2. The goal is to decrease the risk of re-offense by program participants, and to increase public safety, by transitioning clients from prison into the community with intensive community supports and providing on-going services for up to 60 months.

B. Eligibility

Determined by Statewide Review Committee

3.17 Peer Bridger Program

3.17.1 Program

A. The Peer Bridger program is funded by a two-year grant from the Washington State Attorney General's Office, Division of Consumer Protection. Peer Bridger services are available only at Navos Mental Health Solutions inpatient services, and Harborview Medical Center psychiatric inpatient services.

B. Peer Bridgers are state Certified Peer Counselors who work as part of the inpatient treatment team on behalf of hospitalized individuals to facilitate successful transitions to community based services and supports.

C. Peer Bridgers help hospitalized individuals to:

1. Link to medical care, mental health and substance use disorder treatment, housing, employment and peer support services

2. Develop a person centered plan (e.g., WRAP and/or Advance Directive)

3. Apply for financial benefits

4. Engage natural supports

5. Develop wellness self-management and self advocacy skills.

3.17.2 Eligibility

Adult residents of King County who are psychiatrically hospitalized on either a voluntary or an involuntary basis at Harborview Medical Center or Navos Hospital. Participation is voluntary. Individuals will be eligible based on the following criteria:

A. Priority One:

1. Individuals not covered by Medicaid, private insurance, or other source of funding for mental health treatment at the time of admission; and not enrolled in services with a King County Community Mental Health Agency (CMHA), or

2. Individuals covered by Medicaid who are not enrolled with services with a King County CMHA.

B. Priority Two

1. Individuals covered by Medicaid or MIDD Non-Medicaid, enrolled in services with a King County CMHA, and who:

2. Have a history of multiple hospitalizations (two or more within the year prior to admission); and/or face significant barriers that may prevent successful reintegration in the community (e.g., are homeless and/or at risk for homelessness, have a history of incarceration, have a history of poor adherence to prescribed medications or other treatment recommendations, and/or have a co-occurring substance use disorder).

3.17.3 Services are available during hospitalization for all eligible individuals.

A. For individuals not already receiving services from a KCRSN community mental health provider, aftercare peer bridger services may be offered for up to three months.

B. For individuals already enrolled with a KCRSN provider, aftercare peer bridger services may be provided for up to four weeks.

3.18 Re-Entering Offenders Referral Service (RORS), formerly Seriously Mentally Ill Offenders (SMIO)

3.18.1 Program

A. RORS referrals are an effort between the DOC and KCMHP to transition offenders with serious mental illnesses into outpatient services level of care on their release from state DOC custody.

B. Providers shall attempt to engage into treatment clients referred to them through RORS by KCMHP clinical staff.

C. When the provider receives the referral packet from KCMHP clinical staff, the provider will schedule an intake appointment, complete the RORS Intake Appointment form (Attachment A) and fax it to KCMHP within five working days.

D. Within 15 days of the intake appointment, the provider will complete the RORS Intake Disposition Form (Attachment B) and fax it to KCMHP.

3.18.2 Eligibility

A. Determined by the DOC as High Needs "A" or "B" prior to release from prison, and returning to King County and in need of mental health services.

B. Sufficient mental health information, release address, and Medicaid funding pending to make a referral to a network provider.

C. Clients in this program must meet state Access to Care diagnostic criteria. See Section VI, Outpatient Services Level of Care.

3.19 Project for Assistance in Transition from Homelessness (PATH)

3.19.1 Program

The Project for Assistance in Transition from Homelessness (PATH) program provides services for people with serious mental illness, including those with co-occurring substance use disorders, who are experiencing homelessness or at risk of becoming homeless. PATH services include community-based outreach, engagement, and transitional support services. PATH provides screening for benefits and services and case management pending transition into the KCMHP or other long-term services.

3.19.2 Eligibility

A. Persons eligible for PATH services are those who:

1. Are at least 18 years of age;

2. Are homeless or at imminent risk of homelessness;

3. Have a diagnosable and persistent mental or emotional impairment that seriously limits the person's major life activities and may also have co-occurring substance use disorders;

4. Are unable or unwilling to access community-based services through the King County Mental Health Plan (KCMHP) due to clinical reasons and not just financial limitations; and

5. Are not receiving other Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD)-funded ongoing services.

B. Persons are not PATH eligible when:

1. The Veterans Administration (VA) and/or subcontractors of the VA are providing the full range of needed services stipulated by PATH statutes and regulations;

2. Enrolled in the KCMHP and/or other MHCADSD programs and receiving all necessary services that will transition the person from homelessness into psychiatric and medical services, community mental health or co-occurring substance use disorder services, case management services, secure housing, employment services, and/or other services that will assist the person in avoiding homelessness;

3. Housed for a period up to one year; or

4. Receiving all necessary services from other treatment systems.

3.20 Program of Assertive Community Treatment (PACT)

3.20.1 Program

A. PACT is a federally recognized, evidence-based practice that provides comprehensive, individualized assistance to people with severe and persistent mental illness. PACT is intended for individuals who have been frequently hospitalized or incarcerated due to mental illness.

B. The PACT program offers a team approach, small caseloads, fixed point of responsibility, community-based, time unlimited and flexible services, including 24/7 crisis intervention services as needed.

C. For referral, use Attachment C: PACT Eligibility Screening Form

3.20.2 Eligibility

A. Diagnosed with a severe and persistent mental illness, (typically schizophrenia spectrum disorders and bipolar disorder), **and**

B. Significant difficulty in doing day-to-day tasks needed to live independently in the community (i.e., maintaining employment/housing, care of medical or nutritional needs, meeting own personal financial needs), **and**

C. Discharging from WSH or LTR level of care, **or**

D. Have had three or more psychiatric hospitalizations in the past 12 months or hospitalization(s) of significant duration.

3.21 Re-Entry Case Management Services and Homelessness Prevention Program

3.21.1 Program

A. This program provides intensive transitional reentry support (approximately 90 days) and systems navigation to persons released from King County Jail or discharging from a Community Corrections program to community-based resources.

B. Reentry Case Managers assist participants in securing public entitlements, navigating public transportation, addressing basic needs, and with intake and engagement with other community-based services, including ongoing mental health and/or substance use disorder treatment and vocational and housing resources in the community.

C. This program also provides housing retention and rental assistance up to 90 days for eligible adults who are at risk of homelessness.

3.21.2 Eligibility

A. For Re-entry Case Management Services:

1. Have annual income not more than 200 percent of federal poverty level; **and**

2. Have a mental health and/or substance use disorder; **and**

3. Are being released from KCCF or RJC within the last 90 days or being discharged from King County Community Corrections Division Program.

B. For Homelessness Prevention Program:

1. Must meet the eligibility requirements for Re-entry Case Management; **and**

2. Are at risk of losing current rental housing in King County.

3.22 Supported Employment

3.22.1 Program

An evidence-based approach to help people with mental illness find and keep competitive employment within their communities. In accordance with the Substance Abuse and Mental Health Services Administration (SAMHSA), King County RSN identifies the primary principles of Supported Employment as follows:

A. Eligibility is based upon consumer choice. No one is excluded who wants to participate;

B. Supported employment is integrated with mental health treatment. Employment specialists coordinate plans and services with the mental health treatment team;

C. Competitive employment means community jobs that pay at least minimum wage. Employment may be part-time or full-time;

D. Job search starts soon after a consumer expresses interest in working. There are no requirements for completing extensive pre-employment assessment and training, or intermediate work experiences, such as prevocational work units, transitional employment, or sheltered workshops;

E. Follow-up supports are continuous. Individualized supports to maintain employment continue as long as consumers want the assistance; and

F. Consumer preferences are important. Choices and decisions about work and support are individualized based upon the person's preferences, strengths, and experiences.

3.22.2 Eligibility

Adult consumers who are authorized in the following KCMHP programs within the King County provider network are eligible for Supported Employment services:

A. Outpatient or residential/supportive housing benefit;

B. Expanded Community Services benefit;

C. Clubhouse; and

D. Mental Health Integration Project (MHIP)

3.23 Wraparound for Children, Youth, and Families

3.23.1 Program

High-fidelity Wraparound is a proven, effective approach to developing and coordinating care plans that:

A. Build on the strengths of the child, youth, and family;

B. Are individualized and based on the goals identified by the family; and

C. Address the specific cultural needs of the family, with a goal that services and supports occur in the family's home and community whenever possible.

D. A team of supportive individuals 'wraps' around the family to help them achieve their goals. Wraparound reduces reliance on formal systems and increases resilience, self-determination, and overall well-being for families.

3.23.2 Eligibility

Any child or youth (up to age 21) residing in King County who:

A. Is experiencing an emotional and/or behavioral disturbance, including substance use;

B. Receives services from two or more of the following providers: mental health, substance use disorder, child welfare, juvenile justice, developmental disabilities, and/or special education programs;

C. Would benefit from wraparound; and

D. Agrees to participate in the process.

3.23.3 Additionally, any child or youth (up to age 17.5) residing in King County who:

A. Has an emotional or behavioral disturbance; and

B. Is seeking admission to the Children's Long-term Inpatient Programs (CLIP).

3.24 Transition Support Program (TSP)

3.24.1 Program

A. Mobile, multidisciplinary team supports the development and implementation of discharge plans for selected individuals involuntarily detained in King County. Services include:

1. Consults with hospital staff regarding discharge plans and engages program participants in the discharge planning process.

2. Helps program participants – in coordination with hospital discharge planners – identify, contact, and engage the full range of community providers required to successfully transition from the hospital and live as independently as possible in the community.

3. Provides program participants temporary support following hospital discharge to ensure they are actively engaged with the identified community providers and are receiving the services necessary to sustain them in the community and avoid future hospitalizations.

B. The goals of the program are as follows:

1. Reduce the average length of stay for individuals residing in King County community hospitals and psychiatric inpatient units.

2. Help program participants successfully transition from the hospital setting to their homes or other supportive community based settings.

3. Reduce or prevent more acute illness, high-risk behaviors, re-hospitalizations, incarcerations, and other emergency medical or crisis responses for program participants.

3.24.2 Eligibility

A. Individuals boarded at King County hospitals who meet the following conditions:

1. Referred by the King County Designated Mental Health Professionals (DMHPs);

2. 18 years of age or older; and

3. Willing to participate in the TSP.

B. The majority of individuals will be King County residents, but the program will serve individuals without regard to their county of residence.

4.0 LIST OF ATTACHMENTS:

4.1 Attachment A: RORS Intake Appointment Form

4.2 Attachment B: RORS Disposition Form

4.3 Attachment C: PACT Eligibility Screening Form

4.4 Attachment D: MIDD Wraparound Form

5.0 REFERENCES:

Washington State Law, Regulations, and Policy including any successor, amended, or replacement laws, regulations**,** or policies

- Chapters 388-865, 388-877, 388-877A Washington Administrative Code – Department of Social and Health Services – Mental Health – Community Mental Health and Involuntary Treatment Programs
- Chapter 71.24 Revised Code of Washington – Mental Illness – Community Mental Health Services Act
- Federal 1915(b) Waiver Renewal
- 1995 Legislative Budget Proviso concerning Medicaid Personal Care

Other

- The Department of Social and Health Services (DSHS) State Mental Health Contract any subsequent amendments.
- The Department of Social and Health Services (DSHS) PIHP Contract and any subsequent amendments.
- Agreement between the King County RSN, Region 4 Home and Community Services, and the King County Area Agency on the Aging
- Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)

King County

RE-ENTERING OFFENDER REFERRAL SERVICE (RORS) INTAKE APPOINTMENT

In order to maintain accurate records of individuals referred through RORS (formerly SMIO), **please complete the following information, and fax this page to the Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) within five working days** after receiving the referral packet for the individual referred through RORS. Thank you.

CLIENT NAME:

Department of Corrections Number:

This client has an intake appointment scheduled at:

AGENCY: _____

LOCATION: _____

DATE: _____

WITH (name of clinician providing intake):_____

PLEASE RETURN THIS via FAX to:

KCMHCADSD
Attention: Barbara Vannatter
Fax: 206-205-1634
Phone: 206-263-8948

KCMHCADSD use only:
Forwarded to: ☐ Referral Sources: _____
☐ CCO/RMS: _____

Date:

King County

RE-ENTERING OFFENDER REFERRAL SERVICE (RORS) INTAKE DISPOSITION FORM

In order to maintain accurate records of individuals referred through RORS (formerly SMIO), **please complete the following information, and fax this page to the Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) within 15 working days of the intake** for the individual referred through RORS. Thank you.

CLIENT NAME:

Department of Corrections Number:

The client:

1. _____ Attended the intake appointment _____ Did not attend the appointment

2. _____ Received an outpatient benefit _____ Was not eligible for an outpatient benefit

PLEASE FAX THIS FORM TO:

MHCADSD
Attention: Barbara Vanatter
Fax: 206-205-1634
Phone: 206-263-8948

Fax or mail completed form to:
Lisa Floyd
401 Fifth Ave, Suite 400, Seattle, WA 98104
Fax: 206-205-1634
Phone: 206-263-8949

Referral Date: ____/____/____

Team Referral: ____/___/____

King County
Program of Assertive Community Treatment (PACT)
Eligibility Screening

Please attach most recent intake, discharge summary, and/or psychiatric assessment.

Last Name: First Name: Gender: KCID:

Address (or name of current placement): BDAY: AGE:

Last Agency to Provide Ongoing Services Primary Language**:**

Medical Benefit: ☐ Medicaid ☐ Medicare, Part(s): A B C D ☐ Other (_____)

Cash Benefit, Type: ☐ SSI ☐ SSDI ☐ Disability Lifeline ☐ Other (_____)

Cash Benefit, Amount: _____

Referral: ☐ WSH ☐ Local jail ☐ KCRSN ☐ ECS ☐ LTR (name)

☐ Hospital (name) ☐ Other, specify:

Please indicate consumer's length of stay if referral is hospital, jail, or residential facility:

Individual Completing Screen _____
(Print) (Signature)

Contact Phone Email

Diagnosis: (Complete all five axes w/ description / code. Please INCLUDE Substance Use Disorders on Axis I.)

Axis I:	Code:
	Code:
	Code:
Axis II	Code:
	Code:
Axis III	
Axis V : Current GAF Highest Past Year	

An individual must be diagnosed with a severe and persistent mental illness. Priority is given to a diagnosis of schizophrenia, other psychotic disorders (e.g. schizoaffective disorder) and bipolar disorder because these illnesses more often cause long-term disability. If other diagnosis, please explain/justify*:

The PACT teams cannot accept an individual whose sole or primary diagnosis is Dementia, Personality Disorder, Pervasive Developmental Disorder and/or Substance Use Disorder. Such disorders, however, do not exclude an individual with a severe and persistent mental illness.

3. The individual experiences significant functional impairments due to mental illness as demonstrated by the following conditions (please check all that apply):

☐ **Significant difficulty maintaining consistent employment at a self-sustaining level**

☐ **Significant difficulty consistently carrying out the homemaker role (e.g., household meal preparation, washing clothes, budgeting, or child-care tasks and responsibilities)**

☐ **Significant difficulty in consistently performing the range of practical daily living tasks required for basic adult functioning in the community (e.g., caring for personal business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs; maintaining personal hygiene)**

☐ **Persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others such as friends, family, or relatives**

☐ **Significant difficulty maintaining a safe living situation (e.g. repeatedly forgetting to turn stove burners off; excessive hoarding; consistently unsanitary conditions due to uncollected garbage, food scraps and other waste material)**

4. Continuous high-service needs due to mental illness demonstrated by the following (please check all that apply):

☐ **High use of psychiatric hospitals (e.g., two or more admissions per year).**

☐ **Intractable (i.e., persistent or very recurrent) severe major symptoms (e.g., affective, psychotic, suicidal).**

☐ **Coexisting substance use disorder of significant duration (e.g., greater than six months).**

☐ **High risk or recent history of criminal justice involvement (e.g., arrest and incarceration).**

☐ **Significant difficulty meeting basic survival needs or residing in substandard housing, homelessness**

☐ **At imminent risk of becoming homeless (e.g., repeated evictions or loss of housing).**

☐ **Residing in an inpatient, jail, or supervised community residence and clinically assessed to be able to live in a more independent living situation if intensive services are provided**

☐ **Requiring a residential or institutional placement if more intensive services are not available.**

PLEASE DESCRIBE THE REASONS PACT SERVICES ARE REQUIRED FOR THIS INDIVIDUAL.

Please indicate area that consumer hopes to reside upon leaving facility.

☐ **Downtown, North area of Seattle or Northern King County**
☐ **South and Eastern areas of Seattle and King County**
☐ **Outside of King County. Where?**

Print Consumer Initials:

History of Hospitalizations and Law Enforcement Contacts

(Please complete even if admission criteria in these areas are not met)

Psychiatric hospitalizations:

Hospital Name & Location (if known)	ITA/Voluntary	Admission Date	Discharge Date

Other relevant information regarding hospitalizations, if any:

All known <u>arrests or other law enforcement contacts</u>, with details as available:

Date of Arrest	City	State	Charge(s)/Description of contact

Other relevant information regarding arrests or law enforcement contacts, if any:

All <u>incarcerations</u>, with details as available:

Facility Name & Location	Incarceration Date	Release Date	Charge(s)

Other relevant information regarding incarcerations, if any:

Print Consumer Initials:

Functional Baseline Assessment

(Descriptions in each area may not fit individual exactly. They are a guide to help you assess individual within a range. Please choose the description that most closely characterizes the consumer.)

1. What is the consumer's ability to perform self-care tasks (i.e., hygiene, toileting, eating)?

☐ 0.Consumer performs self-care tasks independently	☐ 1. Consumer required occasional prompting or assistance needed	☐ 2. Consumer needs prompting, monitoring, or step-by-step cueing to perform one or more of the self care areas	☐ 3. Consumer does not respond to intensive prompting. Hands on assistance is required

2. What is the consumer's potential to cause harm to self or others (including inability to avoid dangers)?

☐ 0. No indication of suicidal or homicidal thought or impulses and no history and can avoid common dangers in environment	☐ 1. Occasional thoughts of suicide or homicide without plan or means - recently or in the past AND/OR some prompting needed to recognize common dangers	☐ 2. Significant current suicidal or homicidal ideation without intent or conscious plan and with past history AND/OR needs monitoring or assistance to avoid dangers in environment	☐ 3. Current suicidal or homicidal ideation with intent and plan and means likely to be available to carry out this behavior. May be in presence of command hallucinations or delusions which threaten to override usual impulse control. AND/OR unable to avoid dangerous situations even with frequent monitoring.

3. What is the consumer's ability to perform household tasks (e.g., shopping for food, meal preparation, keeping residence reasonably clean, and washing clothes, child-care)?

☐ 0.Performs household tasks independently	☐ 1. Needs some prompting to complete for household tasks	☐ 2. Requires consistent monitoring, assistance and/or supervision	☐ 3. Consumer is unable to perform household chores - even with consistent assistance

4. How does the consumer manage medical condition(s)?

☐ 0. Any illnesses or medical conditions managed sufficiently and independently by consumer	☐ 1. Existence of medical conditions that require some prompting to help the consumer manage symptoms.	☐ 2. Medical conditions exist or have the potential to develop (e.g., diabetes, hypertension) and consumer needs assistance, supervision, and/or monitoring to manage symptoms.	☐ 3. Significant medical conditions exist which are poorly controlled by consumer even with assistance, monitoring and supervision AND are potentially life threatening in the absence of daily management by a medical professional.

5. Which description most closely portrays consumer's perception of his/her mental illness and treatment?

☐ 0. Recognizes mental illness and symptoms of illness; willingly med compliant and initiates treatment; good insight; manages symptoms well	☐ 1. Accepts mental illness to some degree and generally responsive to treatment; may occasionally demonstrate resistance to treatment or deny mental health problems	☐ 2. Demonstrates limited insight and understanding of his/her mental illness; will frequently minimize mental health problems; prompting is often required for med compliance; ambivalent about treatment	☐ 3. Denies mental illness and symptoms; demonstrates little or no insight; non-med compliant without prompting; resists services; symptoms of illness frequently compromise individual's functioning

Which description most closely portrays consumer's social skills…abilities to tolerate others, cooperate, etc?

☐ 0. Mostly "gets along"; if approached, can tolerate input & responds with minimal problems; some ability to negotiate interpersonal differences; has friend(s)	☐ 1. Difficulty coping with stress; sometimes exhibits angry outbursts and non-cooperative with others; accepts limited feedback about behavior; some social contacts	☐ 2. Frequent difficulty engaging positively with others; withdrawn and isolated; minimal insight regarding behavior and consequences; few social contacts	☐ 3. May frequently seem intimidating/off-putting to others and provoke verbal or physical attacks; often responds in angry, profane, or menacing ways; significantly impaired ability to deal with stress; no apparent social network

Print Consumer Initials:

Submit by fax to: Wraparound Program Specialist (206-205-1634)

Referral Date		**Date Received**	
Referring Person		**Agency Name**	
Agency Address		**Phone**	
Fax #		**Email**	

Client Information			
Child's Name		**SSN**	
DOB		**Age**	
Gender		**Ethnicity**	
Resides With		**Relationship**	
Address			
Home Phone		**Work Phone**	
Parent/Guardian		**Phone**	
Address			

Eligibility Criteria & Collaborative Partners ***Wraparound eligibility requires involvement by at least two collaborative partners***			
Check a Box		**Yes**	**No**
Lives In King County			
Is under age 21			
Has an emotional or behavioral disturbance			
Has substance use disorder			
Is willing to participate in the Wraparound Process			
Has family willing to participate in Wraparound Process			
System	**Contact Person**	**Agency**	**Phone Number**
*DCFS			
*Education			
*Mental Health			
*Drug and Alcohol			
*Juvenile Justice			
*DDD			
Public Health			
Medical			
Legal			
Natural Support			
Other			

Special considerations			
Interpreter		**Child Care**	
Transportation		**Other**	

MIDD Wraparound
King County MHCADSD
401 Fifth Avenue, Suite 400, Seattle, WA 98104
FAX: 206-205-1634 Phone: 206-263-8957

MIDD Wraparound

King County

Household Members *(Siblings, foster children, relatives, non-related persons)*		
Name	**Age**	**Relationship**
Enrolled/Suspended/Expelled		
Date of last attendance		
GED Completed (yes/no)		
IEP or 504 Plan		

Family Strengths
Describe the child and family strengths *(attach additional page if necessary)*

Reason For Current Wraparound Request

MIDD Wraparound

King County

Current Functioning Levels		
	Unmet Need	**Desired Goal**
Living Situation		
Family		
Education and Vocational		
Legal		
Mental Health		
Social/Recreational		
Medical		
Cultural/Spiritual		
Drug and Alcohol (including tobacco use)		
Other		

KC MIDD Wraparound official use:

Date Referral Received: _____

_____Meets eligibility criteria for Wraparound

Faxed to Wraparound Delivery Team # _____ Date Sent: _____

Coach: _____

Phone: _____ Fax: _____

Initials: _____

MIDD Wraparound

King County

Authorization for Mutual Exchange of Confidential Information

King County MIDD Wraparound represents an effort to implement system collaboration on behalf of at-risk children and youth within the boundaries of King County through the ongoing efforts of families, their supports, local child-serving agencies, and school districts. The purpose of this form is to allow the mutual exchange of information between the King County MIDD Wraparound Delivery Team, families, child-serving agencies, schools, and/or other individuals pertaining to:

Name: _____ Date of Birth: _____ Age: _____

Information so authorized includes all information necessary for the administration of MIDD Wraparound in coordinating a planning process leading to an individualized care plan and development of a child and family team. Information is not limited to medical, social, psychological, behavioral, academic, family, and treatment history.

The specific purpose of this exchange of information is as follows: _____

_____

Agencies and persons involved will be asked to participate on the child and family team. The following persons/agencies are currently involved with the youth and family and/or have requested to participate on the team.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

I hereby give my permission to exchange information pertaining to my child. I understand this information is confidential. To revoke this authorization for release of information, I must do so in writing. This release expires at discontinuance from MIDD Wraparound unless otherwise specified here: EXPIRES
_____

Parent/Guardian Signature: _____ Date: _____

Youth (13+ years) Signature: _____ Date: _____

Witness Signature: _____ Date: _____

X. QUALITY MANAGEMENT AND EXTRAORDINARY OCCURRENCES

1.0 POLICY TITLE: QUALITY MANAGEMENT OF THE KING COUNTY MENTAL HEALTH PLAN (KCMHP), INCLUDING EXTRAORDINARY OCCURRENCES

1.1 Originally Implemented:

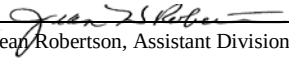
1.1.1 Quality Management: April 1, 1995

1.1.2 Extraordinary Occurrences: January 1, 1996

1.2 Reviewed and revised: November 2014

1.3 Officially Adopted: January 2, 2015

1.4 Effective Date: February 2, 2015

1.5 Signed: 

Jean Robertson, Assistant Division Director/RSN Administrator

2.0 PURPOSE: To describe the processes that the King County Mental Health Plan (KCMHP) utilizes to ensure that services are timely, accessible, appropriate, effective for clients, and cost-effective for the system.

To define safety and risk management as it pertains to extraordinary occurrences and to ensure that all contracted and subcontracted providers promptly and accurately report these occurrences to KCMHP, analyze them for causative factors, cooperate with KCMHP reviews, and implement quality improvements and/or corrective actions to decrease the likelihood of future similar occurrences.

KCMHP encourages a system-wide culture that emphasizes accountability, trust, and continuous system improvement and learning.

3.0 POLICY/PROCEDURES/RESPONSIBILITIES:

3.1 Quality Management:

3.1.1 Quality Management Plans

A. MHCADSD shall develop and implement an annual quality management plan.

1. The plan is monitored and revised by the MHCADSD quality management committee, Senior Staff Group

2. The plan is reviewed by the King County Mental Health Board, the Quality Council, providers, and other stakeholders.

3. The impact and efficacy of the KCMHP Quality Management Program shall be evaluated annually. This evaluation will be documented in a summary report that includes:

a. A summary of quality improvement activities, projects, and products;

b. An evaluation of the overall effectiveness of these efforts; and

c. Progress toward improving clinical and administrative practices.

B. Providers shall develop and implement quality management plans that include:

1. How the provider shall meet the requirements of Chapter 388-877 Washington Administrative Code (WAC) or its successor, the contract with KCMHP, and this manual;

2. Processes for developing performance indicators, collecting and evaluating data, and monitoring performance and outcomes;

3. Processes for responding to and monitoring all client complaints and grievances; and

4. Processes for implementing quality improvements and/or corrective actions when indicated.

C. KCMHP shall assess the effectiveness of provider quality management plans through:

1. Clinical and/or administrative site reviews; and

2. Review of annual quality management plans submitted to KCMHP.

3.1.2 Quality Management Activities

A. KCMHP and individual providers shall be separately and jointly responsible for identifying and implementing quality improvement activities.

KCMHP shall initiate quality improvement activities when concerns are identified through the analysis of outcomes, critical indicators, exception reporting, complaints and grievances, contract compliance site visits, and/or re-credentialing.

1. Providers, clients, and community stakeholders shall be invited to participate in work groups to address system-level quality concerns.

2. Work groups shall study the identified concern and provide KCMHP with recommendations for improvement.

3. KCMHP shall consider the recommendations and decide upon and implement an action plan.

4. KCMHP shall review the results of the implemented action plan with the work group, and with other stakeholders when appropriate.

5. KCMHP shall make any necessary changes in the action plan based upon work group and/or stakeholder feedback.

B. Providers shall undertake quality improvement activities to address concerns identified through provider internal quality management processes. These quality improvement activities shall:

1. Be designed to meet standards prescribed in this manual and/or contracts;

2. Incorporate client and relevant stakeholder input; and

3. Document the implementation and efficacy of the improvement processes.

3.1.3 Minimum Compliance Requirements and Guidelines

A. KCMHP shall perform compliance reviews through the monitoring of exception reporting, complaints and grievances, clinical and administrative site visits, and/or credentialing.

B. KCMHP shall analyze information system data and client records to identify trends and patterns of service delivery and to monitor for quality, cost, utilization, and access.

C. Minimum requirements and guidelines (see 3.1.3.D below) shall be established to ensure the quality of service provision. These requirements and guidelines shall be reviewed and updated biannually and shall apply to KCMHP network providers.

D. Compliance with these minimum requirements and the guidelines listed below shall be monitored by review of extraordinary occurrences, appeals, complaints and grievances, authorization requests, case consultations, contract compliance site visits and/or re-credentialing.

Guidelines and Minimum Requirements	See Attachment
1. Guidelines for Older Adults in Community Support Services	A
2. Minimum Requirements for Care of Mentally Ill Clients with HIV/AIDS	B
3. Minimum Requirements and Certification for Mental Health Professionals	C
4. Minimum Requirements for Sexual Minority Mental Health Specialists	D
5. Diagnosis-Specific Practice Guidelines	E
6. Guidelines for Psychiatric Consultation and Evaluation	F
7. Wraparound Practice Guidelines	G
8. Developmental Practice Guidelines (summary format)	H

3.1.4 Where feasible and appropriate, providers shall utilize evidence-based, best practice, and/or promising practice interventions to address the needs of clients.

A. "Practice Protocols for Peer Support" (See Attachment I) were adopted as a best practice model in 2014. "Practice Protocols for Recovery and Resiliency-oriented Mental Health Services" (See Attachment L) shall be adopted as a best practice model in 2015.

1. Providers may incorporate and prioritize adoption of any, or all of these Protocols as a component of their quality improvement plan.

2. These Protocols will be adopted as formal Guidelines (as per 3.1.3) in a future year.

B. A stakeholder process will be utilized to select any additional promising/best practices in future years.

3.1.5 Performance and Outcome Measurement

A. KCMHP shall establish and track system performance and individual outcome measures.

B. KCMHP shall publish regular reports of system and provider-specific performance.

3.1.6 Quality Review Team (QRT)

A. The KCMHP quality management process shall include assessment of client and referral-source satisfaction with service.

B. KCMHP shall establish a QRT per Chapter 388-865-0282 WAC or its successor to:

1. Promote recovery and resiliency for clients; and

2. Review KCMHP and provider performance, including but not limited to, the following:

a. The degree to which services are consumer-driven, accessible, and culturally and age appropriate;

b. Service quality; and

c. Client satisfaction and client welfare.

C. The KCRSN and providers shall facilitate access to provider facilities and to documents necessary for the QRT to fulfill its function.

D. Providers shall work with the QRT to ensure that client surveys can be administered.

E. Providers shall notify clients that they may be contacted by the QRT and asked to voluntarily participate in client satisfaction surveys and other activities that promote client education and individual recovery and resiliency.

F. QRT findings and reports shall be distributed to providers and other community stakeholders. Providers shall work with the KCMHP and the QRT to implement recommended system improvements.

3.1.7 Quality Council

KCMHP and providers shall support the Quality Council, a King County Mental Health Board committee that serves as an oversight and advisory group related to quality of care and client satisfaction.

3.2 Extraordinary occurrences:

3.2.1 An Extraordinary Occurrence is defined as:

A. Death – incidents related to mental illness or substance use, and/or their treatment(s); suicide; homicide (whether the client is a victim or perpetrator); and all deaths for all reasons when the client is in a psychiatric hospital, residential program, or other mental illness treatment facility. A death whose possible relationship to mental illness or substance use, or their treatment(s) cannot reasonably be initially ruled out shall be reported. A death that is determined by the medical examiner to be "natural" may still fit this definition of an extraordinary occurrence death;

B. Assault by a client – the intentional infliction of bodily harm that causes a person, including agency staff, to seek medical treatment or results in an arrest. This category also includes sexual assault, regardless of the degree of the injury;

C. Injury to a client

1. The sustaining of bodily harm by a client (including suicide attempts) that necessitates seeking urgent medical attention, and which:

a. Is related to the client's mental impairment or treatment, including medication errors made by professional staff; or

b. Takes place on the treating program property;

OR:

2. Alleged rape or sexual assault that is deemed by the provider agency to be sufficiently credible to report to the police;

D. Damage to property – the intentional damage by a client to property, such that the incident is likely to be reported in the media or be the subject of a complaint to public officials outside KCMHP;

E. Behavior – client behavior so bizarre, disruptive, or threatening that it is reported to police, likely to be reported in the media, or to be of concern to public officials outside KCMHP;

F. Elopement – unauthorized departure by a client from a "more restrictive" civil commitment under Chapter 71.05 Revised Code of Washington (RCW) or its successor;

G. Financial exploitation involving a client or the agency;

H. Client abuse or neglect of a serious nature by an employee, volunteer, licensee, or another client; and

1. For definition of abuse/neglect, providers should reference WAC 246-16 or its successor regarding reporting of mandatory abuse, neglect or exploitation consistent with Chapters 26.44 and 74.34 RCW or any successor.

I. Occurrences that fall outside the above definitions may be reported and shall be reported at the request of the KCMHP.

3.2.2 Reporting time frames

A. Extraordinary occurrences are reportable when the events occur during the time in which a client is receiving services. This time frame varies according to the goals and responsibilities of the program.

The time frame for the following programs is defined as follows:

1. For outpatient and residential providers, from the time of admission to time of discharge;

2. For crisis services, from time of referral/admission to five days after time of discharge. Crisis services include, and are not limited to hospital diversion beds, crisis respite beds, mental health detox beds, next day appointments, and Evaluation and Treatment facility beds on contract to KCMHP.

3. Occurrences that fall outside the above time frames may be reported.

B. Deaths or serious injuries that occur at agency facilities, or violent acts including rape, sexual assault, homicide or attempted homicide involving any individual who has been served within 365 days of the occurrence.

1. Reports shall be submitted if/when an agency becomes aware of an incident.

2. Reports do not include any requirement to track or investigate current information on clients who are no longer being served by an agency.

3.2.3 Reporting

A. Reports of elopement from involuntary treatment should include the grounds for the detention: danger to self, danger to others, danger to property, and/or gravely disabled.

B. Incidents involving a death are to be reported verbally to the KCMHP Client Services staff within one working day.

C. The provider shall submit a completed "Extraordinary Occurrence Report" (Attachment J) to KCMHP within five working days of the incident.

D. If the provider is a subcontractor, Attachment A shall also be sent to the contracting agency.

E. The requirement to report to KCMHP does not replace reporting requirements to other entities.

3.2.4 Review

A. The provider shall maintain:

1. A Standard Review Committee consisting of the clinical and medical directors, quality improvement/quality assurance staff, supervisors, and other appropriate staff as necessary; and

2. Procedures for review and critical analysis of any causal factors for extraordinary occurrences.

B. The provider shall complete a "30-Day Standard Review" (Attachment K) within 30 days of the occurrence. The review is to be kept on file at the provider agency and is not submitted to KCMHP.

C. If an autopsy is performed, the provider must complete a revised 30-Day Standard Review that reflects the medical examiner's information within three months of the incident. This review is to be kept on file at the provider agency and is not submitted to KCMHP.

D. The provider review shall comprise:

1. The identification of all factors that might have contributed to the extraordinary occurrence;

2. The identification of any factors that might be altered in the future to prevent similar extraordinary occurrences involving the client and/or other clients in similar circumstances;

3. Specific strategies to prevent future occurrences, for example:

a. A change in the individual client's individual service plan (ISP);

b. A new policy and procedure for addressing the needs of similar clients;

c. New or augmented staff supervision practices;

d. New management practices;

e. Staff training;

f. Staff disciplinary action;

g. Recommendations for policy and procedure changes to KCMHP; and/or

h. Other interventions; and

4. The identification of any unprofessional conduct by an individual staff person, as defined in Chapter 18.130 RCW or its successor. Whenever unprofessional conduct is identified and is of such a degree that the staff person is terminated or restricted in the performance of his/her clinical duties, whether or not due to an event that meets the above definitions for an extraordinary occurrence, this shall be reported to the Washington State Health Professions Quality Assurance office.

E. The KCMHP shall complete an annual report about system trends related to extraordinary occurrences, quality improvement initiatives related to these occurrences, and improvements attained.

1. This report is reviewed by the MHCADSD Safety and Incident Management Committee and by providers annually.

3.2.5 KCMHP Quality Reviews

A. KCMHP Client Services staff shall perform a quality review of selected extraordinary occurrences.

B. Quality reviews shall generally occur after the provider's review has been completed but may occur immediately following the occurrence.

C. The provider shall be prepared to discuss its review of the extraordinary occurrence with KCMHP within 30 days of the extraordinary occurrence.

D. The provider shall provide documents and information to facilitate any investigation deemed necessary by KCMHP.

E. Quality reviews shall focus on the quality of the provider's internal review, and may extend to a review of any agency policy or practice.

F. Quality reviews may result in recommendations or requirements for corrective action. The provider shall ensure that all plans for corrective action are implemented, whether imposed by the KCMHP or the provider's own Standard Review Committee.

4.0 LIST OF ATTACHMENTS:

4.1 Attachment A: Guidelines for Treating Older Adults

4.2 Attachment B: Guidelines for Treating Persons with HIV/AIDS

4.3 Attachment C: Certification for Mental Health Professionals

4.4 Attachment D: Sexuality Minority Mental Health Specialist

4.5 Attachment E: Diagnosis-Specific Guidelines

4.5.1 Appendix 1: Additional Signs and Symptoms of Mental Health Disorders in Children and Youth

4.5.2 Appendix 2: Recommendations Regarding Medication Prescription and Monitoring for Children

4.6 Attachment F: Psychiatric Consultation Guidelines

4.7 Attachment G: Wraparound Guidelines

4.8 Attachment H: Developmental Guidelines

4.9 Attachment I: Practice Protocols for Peer Support

4.10 Attachment J: Extraordinary Occurrences Report Form

4.11 Attachment K: Extraordinary Occurrences 30 Day Report Form

4.12 Attachment L: Practice Protocols for Recovery and Resiliency-oriented Mental Health Services

5.0 REFERENCES:

Federal Law, Regulations, and Policy including any successor, amended, or replacement laws**,** regulations**,** or policies

- 42 Code of Federal Regulations (CFR) Part 438 Managed Care
- 42 CFR Parts 400, 430, 431, 434, 435, 440
- 45 CFR Part 142 Security and Electronic Signature Standards
- 45 CFR Parts 160 and 164 Standards for Privacy of Individually Identifiable Health Information

- 45 CFR Part 162 Health Insurance Reform: Modifications to Standards for Electronic Transactions and Code Sets

Washington State Law, Regulations, and Policy including any successor, amended, or replacement laws**,** regulations**,** or policies

- Chapters 388-865, 388-877, and 388-877A WAC – Department of Social and Health Services – Mental Health – Community Mental Health and Involuntary Treatment Programs

- Federal 1915(b) Waiver Renewal

Other

- The Department of Social and Health Services (DSHS) State Mental Health Contract and any subsequent amendments

- The Department of Social and Health Services (DSHS) PIHP Contract and any subsequent amendments

Guidelines for Older Adults in Community Support Services

Purpose:
To provide guidelines and standards for KCMHP services and supports for older adults.

Service Population:
Adults aged 60 years and older who are receiving mental health services funded in whole or in part by the KCMHP. All RSN-funded carve-outs are exempt from these requirements with the exception of Long-Term Rehabilitation (LTR) services. Providers exempt from these requirements should make every effort to ensure that the particular needs of older adults are considered when planning and delivering services.

Requirements:
Providers of direct services to older adults shall be responsible for the provision of age appropriate, medically and clinically competent and relevant mental health assessments and services. Providers shall identify the Geriatric Mental Health Specialist who is accountable for ensuring that mental health services are provided to older adults in accordance with the requirements contained in this document and according to the Washington Administrative Code (WAC) 388-865-0260 criteria or its successor.

Clinical Standards:
The following define the established standards for services to older adults.

1. Individual Service Plans (ISPs) for older adults shall be developed using the same procedures for all adults. However, upon entry into mental health services, the provider shall obtain or develop an assessment of the older adult as explained in this section.

2. In addition to benefit specific assessment requirements, the following assessments must also be completed for all older adult clients authorized for services at all case rates and for older adults receiving LTR benefits:

    a. The significant findings of a **current medical exam** (completed in the preceding 90 days by an MD, DO, ARNP or an alternative health care provider) and a complete medical history, including current and chronic health conditions; past hospitalizations and surgeries for acute problems; current medications both prescribed and over the counter; names and phone numbers of primary and other physicians and/or healer(s), other health care providers, and caregivers; and assessment of the person's willingness/ability to comply with medication and treatment regimen;

    b. Complete **social cultural history** including current support system (family, social, and professional); eligibility for social security, services from the aging network, and the Department of Social and Health Services (DSHS), Aging and Adult Field Services (AAFS); names and phone numbers of other professional service providers, guardians, holders of power of attorney or representative payeeships; and assessment of the adequacy of the current care arrangements;

    c. An assessment of cognitive functioning that includes orientation, short-term and long-term memory, source of information, judgment in issues of health, money and safety, abstract thinking, and insight. The Mini-Mental Status Exam (MMSE) meets requirements for this assessment;

d. A functional assessment, conducted by the case manager or an occupational therapist, of the ability to perform simple and complex activities of daily living and community living skills, communication skills, sensory impairments, mobility, continence, self-care for health problems, and ability to function in the current environment; and

e. Assessment of eligibility for and medical necessity of Medicare-supported mental health services.

3. The provider is encouraged to obtain information directly from the individual, his/her family, and persons immediately responsible for the care of the older adult but may arrange for pieces of the assessment to be done by other qualified specialized services, e.g., Division on Aging (DOA) case managers, DSHS, AAFS Community Nurse Consultants, etc.

4. The provider shall ensure that each older adult has access to the necessary health care and support services required to maintain basic levels of health, hygiene and safety in the least restrictive environment. The provider shall actively pursue coordination of services on behalf of individual clients and shall identify systems, organizations, and providers who might participate in meeting the comprehensive needs of each client, e.g., the DOA, AAFS and Adult Protective Services.

5. The provider shall develop a written policy with regard to the provision of complicated information and the use of written authorization from persons with dementia.

Documentation:
The client file shall clearly document the fulfillment of the requirements in this exhibit.

1. DSHS, AAFS, Comprehensive Assessment and the normal provider intake form complying with Chapter 388-877-0610 WAC or its successor, may be used to fulfill the assessment requirements listed in this exhibit.

2. Documentation of cognitive assessments shall include recording of actual questions and responses used to support clinical conclusion. The Mini-Mental Status Exam (MMSE) meets requirements for this assessment.

3. Providers shall cooperate and participate in quality improvement/quality assurance efforts e.g., conducting satisfaction surveys, monitoring suicide occurrences, implementing quality improvement initiatives.

Informed Consent:
Providers shall ensure that older adults are allowed opportunities for informed consent as per 388-877-0600 Individual Rights, WAC 388-877-0640 Access to clinical records procedures, WAC 388-87A-0180 Pyschiatric medication services, and WAC 388-865-0230 Community Support Services or any successors.

Training and Supervision:
The following establish the standards for those who provide services to older adults.

1. Training

    a. The provider shall ensure that the clinical qualifications of individual(s) providing and/or supervising direct treatment services to all persons 60 years of age or older reflect the special needs of this age group.

    b. All case aides and other non-professional persons providing direct services to older adults must have completed 15 actual hours of training in the special needs, treatment requirements, and (where applicable) community resources of older adults, prior to or within six months from the time of employment.

    c. All case managers, therapists, and other professionals providing direct services to older adults must have completed 24 hours of training in the special needs, treatment requirements, and community resources for the elderly, prior to or within six months from the time of employment.

    d. All full-time case managers, therapists, and other professionals providing direct services to older adults must have six hours of in-service training or other continuing education in the field of older adult mental health each year. Part-time employees will be required to have a pro-rated number of continuing education hours.

2. Supervision

    a. Clinical supervision by Geriatric Mental Health Specialists must be provided in face-to-face contact with the direct service staff at least every other week. For case managers with primary responsibility for fewer than three older adults, face-to-face supervision must be provided at least monthly. All ISPs, determinations of authorization, and concurrent reviews shall be reviewed and approved or provided by the older adult specialist of record.

    b. Medical and/or nursing consultation must be available to each direct service staff that provides services to older adults.

    c. After-hours staff must have access to consultation from a Geriatric Mental Health Specialist.

References:
Chapters 388-865, 388-877, and 388-877A WAC – Community Mental Health and Involuntary Treatment Programs including any successor, amended, or replacement regulations

Minimum Requirements for Care of Mentally Ill Persons with HIV/AIDS

Purpose:
To improve the quality of care for mentally ill clients with HIV/AIDS.

Requirements:
KCMHP providers and sub-contractors shall have policies in place that are specific to persons with AIDS or HIV or who are at risk of acquiring HIV. These policies shall address the following:

1. Confidentiality;
2. Testing;
3. Infection control; and
4. Discrimination.

Minimum Requirements and Certification for Mental Health Professionals

Purpose:
To define the process for obtaining a time-limited exception status or waiver request as a Mental Health Professional (MHP) under Chapter 388-865 Washington Administrative Code (WAC) or its successor in the King County Regional Support Network (RSN)/Mental Health Plan (MHP).

Procedures:
All requests for MHP exceptions or waivers from KCMHP providers shall be reviewed by KCMHP. Applications submitted in writing that appear to meet all requirements will be forwarded to the State Department of Social and Health Services (DSHS) for approval. Entities that are not KCMHP providers must apply directly to DSHS.

1. Request for exception of the requirements of a MHP for an individual with less than a master's degree level of training.

    a. The provider must assure that periodic supervisory evaluations of the individual's job performance are conducted. KCMHP providers must submit copies of the supervisory evaluations within 30 days of completion to the KCMHP, which will maintain them with exception application documentation.

    b. The individual who is requesting a time-limited exception of the requirements of a MHP must submit a plan of action to assure the individual will become qualified no later than two years from the date of exception.

    c. The exception request may not be transferred to another RSN or for use by an individual other than the one named in the exception.

    d. The RSN or entity may apply for renewal of the exception.

2. Request for waiver of minimum standards for a MHP as defined in WAC 388-865-0150.

    a. In no case will DSHS write a waiver of minimum standards for more than the time period of the entity's current license and/or certificate.

    b. Waivers may be renewed.

    c. DSHS does not waive any requirement that is part of statute.

KCMHP providers should mail the completed form and any other required documentation to:

King County Mental Health, Chemical Abuse and Dependency Services Division
Attn: Clinical Services Specialist
The Chinook Building
401 Fifth Ave, Suite 400
Seattle, WA 98104-2333

206-263-8948

MENTAL HEALTH PROFESSIONAL
REQUEST FOR EXCEPTION OF REQUIREMENTS – WAC 388-865-0265
KING COUNTY REGIONAL SUPPORT NETWORK/MENTAL HEALTH PLAN

Date:

Please attach supporting documentation to this request at the time of submission. Documentation may include but is not limited to transcripts, training courses, curriculum vitae and/or copies of degrees and certificates.

The Regional Support Network may request an exception of the requirements of a mental health professional for a person with less than a master's degree level of training. The Department of Social and Health Services may grant an exception of the minimum requirements on a time-limited basis and only with a demonstrated need for an exception as described below.

"Mental health professional" (per WAC 388-865-0150) means:

1. A psychiatrist, psychologist, psychiatric nurse or social worker as defined in Chapters 71.05 and 71.34 Revised Code of Washington (RCW);
2. A person with a master's degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such a person shall have, in addition, at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a mental health professional;
3. A person who meets the waiver criteria of RCW 71.24.260, which was granted prior to 1986;
4. A person who had an approved waiver to perform the duties of a mental health professional that was requested by the Regional Support Network and granted by the Department of Social and Health Services prior to July 1,2001; or
5. A person who has been granted a time-limited exception of the minimum requirements of a mental health professional by the Department of Social and Health Services consistent with WAC 388-865-0265.

Name of Applicant *(Person for whom the exception is being requested)***:**

Provider agency with whom the above applicant is employed:

Contracted with RSN? ____ YES ____ NO

Functions that the person will be performing:

(Functions, cont.)

Statement of need for the exception:

Please attach documentation to verify the following minimum qualifications:

1. Bachelor of Arts or Sciences degree from an accredited college or university.

   Degree: _____ Year: _____ Institution: _____

2. Course work or training in making diagnoses, assessments, and developing treatment plans
3. Documentation of at least five years of direct treatment of persons with a mental illness under the supervision of a mental health professional.

Plan of action to ensure that this individual will become qualified no later than two years from the date of exception approval.

Statement of support by the Regional Support Network *(not required if agency is not contracted with the local Regional Support Network)***:**

I assure that periodic supervisory evaluations of this individual's job performance are conducted.

RSN or Provider Representative **Date**

MENTAL HEALTH PROFESSIONAL
REQUEST FOR WAIVER OF MINIMUM STANDARDS – WAC 388-865-0120
KING COUNTY REGIONAL SUPPORT NETWORK/MENTAL HEALTH PLAN

DATE:

Please attach supporting documentation to this request at the time of submission. Documentation may include but is not limited to transcripts, training courses, curriculum vitae, and copies of degrees and certificates.

The following is a request to waive minimum standards for mental health professional (MHP) as defined in WAC 388-865-0150:

"Mental health professional" means:

6. A psychiatrist, psychologist, psychiatric nurse or social worker as defined in Chapters 71.05 and 71.34 RCW;
7. A person with a master's degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such a person shall have, in addition, at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a mental health professional;
8. A person who meets the waiver criteria of RCW 71.24.260, which was granted prior to 1986;
9. A person who had an approved waiver to perform the duties of a mental health professional that was requested by the Regional Support Network and granted by the Department of Social and Health Services prior to July 1,2001; or
10. A person who has been granted a time-limited exception of the minimum requirements of a mental health professional by the Department of Social and Health Services consistent with WAC 388-865-0265.

Name of entity making request: _____

Address: _____

Phone Number: _____

Applicant *(Person on whose behalf the request is being submitted)***:** _____

Section or subsection to be waived: _____

Reason why the waiver is necessary:

OR:

Method that will be used to meet the desired outcome of the section or subsection in a more effective and efficient manner:

How will results / outcomes of this improved method be tested to ensure that the intent of the section or subsection is met?

Please use the following space to describe the qualifications of the person for whom the waiver is being sought, the justification for the waiver, and the *plan and timetable to achieve compliance* with the minimum standard; and to implement, test, and report results of an improved way to meet the intent of the section or subsection.

Please use the space below to describe any recommendation from the quality review team or Ombuds staff and a description of how consumers will be notified of changes made as a result of this waiver. Please write in "N/A" if this section does not apply.

RSN statement of support:

I recommend approval of this waiver request for *(Name of Applicant)***:** _____

Signature of RSN Representative **Date Signed**

WAIVER/EXCEPTION FACT SHEET

Reference	RCW/WAC LANGUAGE Information/Context/Rules	Who Submits	Time Frame
RCW 71.24.260 [1986 c274 §10]	Waiver of postgraduate educational requirements: The department shall waive postgraduate educational requirements applicable to mental health professionals under this chapter for those persons who have a bachelor's degree *and on June 11, 1986:* Are employed by an agency subject to licensure under this chapter, the community mental health services act, in a capacity involving the treatment of mental illness; and have *at least ten years* of full-time experience in the treatment of mental illness (1986-c 274 / 10)	Anyone can request a waiver	RCW is silent on time frame. Once it was waived (in 1986), it was waived for good.

Reference	RCW/WAC LANGUAGE Information/Context/Rules	Who Submits	Time Frame
WAC 388-865-0120 Filed 5/31/01, eff. 7/1/01 **Statutory Authority**: RCW 71.05.560, 71.24.035(5)(c), 71.34.800; 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, **No requirement that is part of statute can be waived**	Waiver of a minimum standard of this chapter: A regional support network, mental health prepaid health plan, service provider or applicant …may request a waiver of any section or subsection of these rules by submitting a request in writing to the director of the Department of Social and Health Services. (1) The request must contain: (a) The name and address of the entity that is making the request; (b) The specific section or subsection of these rules for which a waiver is being requested; (c) The reason why the waiver is necessary, or the method the entity will use to meet the desired outcome of the section or subsection in a more effective and efficient manner; (d) A description of the plan and timetable to achieve compliance with the minimum standard or to implement, test, and report results of an improved way to meet the intent of the section or subsection. In no case will the Department of Social and Health Services write a waiver of minimum standards for more than the time period of the entity's current license and/or certificate. (2) For agencies contracting with a regional support network or mental health prepaid health plan, a statement by the regional support network or mental health prepaid health plan recommending Department of Social and Health Services approval of the request, including: (a) Recommendations, if any, from the quality review team or ombuds staff; and (b) A description of how consumers will be notified of changes made as a result of the exception. (3) The Department of Social and Health Services makes a determination on the waiver request within 30 days from date of receipt. The review will consider the impact on accountability, accessibility, efficiency, consumer satisfaction, and quality of care and any violations of the request with state or federal law. (4) When granting the request, the Department of Social and Health Services issues a notice to the person making the request, and the involved regional support network if the regional support network is not the applicant, that includes: (a) The section or subsection waived; (b) The conditions of acceptance; (c) The time frame for which the waiver is approved; (d) Notification that the agreement may be reviewed by the Department of Social and Health Services and renewed, if requested. (5) When denying the request, the Department of Social and Health Services includes the reason for the decision in the notice sent to the person making the request. (6) The Department of Social and Health Services does not waive any requirement that is part of statute.	RSN, PIHP, applicant or service provider subject to the rules of the Community Mental Health Act **DSHS must make a decision within 30 days**	As specified by the applicant, but **No longer than the time period of the entity's current license or certificate** May be renewed

Reference	RCW/WAC LANGUAGE Information/Context/Rules	Who Submits	Time Frame
WAC 388-865-0265 **Filed 5/31/01, eff. 7/1/01** **Statutory Authority**: RCW 71.05.560, 71.24.035, 9.41.047, 43.20B.020 and 43.20B.335.01-12-047	**Mental Health Professional – Exception.** The regional support network may request an exception of the requirements of a mental health professional for a person with less than a master's degree level of training. The Department of Social and Health Services may grant an exception of the minimum requirements on a time-limited basis and only with a demonstrated need for an exception under the following conditions: **(1) The regional support network has made a written request for an exception including:** (a) Demonstration of the need for an exception; (b) The name of the person for whom an exception is being requested; (c) The functions which the person will be performing; (d) A statement from the regional support network that the person is qualified to perform the required functions based on verification of required education and training, including: (i) Bachelor of Arts or Sciences degree from an accredited college or university; (ii) Course work or training in making diagnoses, assessments, and developing treatment plans; and (iii) Documentation of at least five years of direct treatment of persons with mental illness under the supervision of a mental health professional. (2) The regional support network assures that periodic supervisory evaluations of the individual's job performance are conducted; (3) The regional support network submits a plan of action to assure the individual will become qualified no later than two years from the date of exception. The regional support network may apply for renewal of the exception. The exception may not be transferred to another regional support network or to use for an individual other than the one named in the exception; (4) If compliance with this rule causes a disproportionate economic impact on a small business as defined in the Regulatory Fairness Act, Chapter 19.85 RCW, and the business does not contract with a regional support network, the small business may request the exception directly from the Department of Social and Health Services.	Person requiring an exception works for an agency subject to the chapter. RSN must make a written request If agency is not contracted with the RSN, may request directly from DSHS	**2 year limit** RSN may apply for renewal **Exception may not be transferred**

Minimum Requirements for Sexual Minority Mental Health Specialist

Purpose:
To expand the scope and vision of Washington Administrative Code 388-865-0260 or its successor to provide for specialized care for persons who are members of a sexual minority group and to specify the training and qualifications for persons who shall provide that care under the designation of sexual minority mental health specialist.

Requirements:
The provider shall ensure that services directed to clients who identify as members of a sexual minority are provided by, under the supervision of, or with consultation from, a sexual minority mental health specialist as defined in this exhibit.

Criteria:
A sexual minority mental health specialist shall meet all of the following criteria:

1. Meet the criteria for certification as a mental health professional as defined in Section X Quality Management, Attachment C, "Certification for Mental Health Professionals."

2. Complete a minimum of 100 actual hours (not quarter or semester hours) of specialized training in the form of course work, independent study, seminars or workshops devoted to a broad range of sexual minority issues and effects of culture on mental health.

3. Have the equivalent of one year of full-time direct service with the sexual minority population under the supervision of a mental health professional meeting the criteria of a sexual minority specialist as defined in this exhibit. Direct service caseload shall include a predominance of sexual minority clients.

4. Demonstrate cultural competence attained through on-going training or study regarding sexual minority issues in the forms of course work, workshops, independent study and seminars totaling 8 to 16 hours per year.

Diagnosis-Specific Practice Guidelines

Diagnosis-Specific Practice Guidelines: Children

Purpose:
To provide guidelines for the appropriate assessment and treatment of children and youth related to specific diagnoses.

Requirements:
Providers shall enhance diagnostic accuracy and consistency by developing and/or improving internal policies and procedures that lead to accuracy and consistency in diagnosis by the mental health professional responsible for the client's care and any prescriber who has evaluated and/or provided treatment to the client. Providers' policies and procedures shall also ensure that the diagnostic information submitted to the KCMHP is consistent with the diagnoses indicated in the clinical chart. When the diagnostic guidelines are not felt to be clinically indicated for a particular client, the rationale for not following the guidelines shall be documented in the chart.

The diagnosis-specific guidelines below are not intended to require treatment that runs counter to client choice, client preferences, client safety or provider treatment recommendations that are deemed and documented to be more clinically desirable for the individual client. It is important to note that these guidelines are not exhaustive and do not encompass all components of client diagnosis and treatment.

For each of the diagnoses outlined below, providers are encouraged to refer to **Appendix 1** which elucidates the variable signs and symptoms that providers may encounter in youth and children due to developmental level and/or cultural differences. Appropriate and effective diagnoses shall take into account development and culture. Providers are encouraged to also refer to **Appendix 2** which outlines practice recommendations for child and youth clients who are receiving psychiatric medication. For young children, refer to Section VI, Attachment A, which provides guidelines regarding use of the DC03, and Section XII, Attachment B, which provides a crosswalk between DCO3 diagnoses and DSM-IV-TR diagnoses.

Procedures:
Providers shall ensure the following steps are taken:

1. All client diagnoses shall be justified in the chart. The discussion and documentation of evidence such as family history of mental illness, discussion of cultural factors affecting differential diagnoses, and review of symptoms to rule out other possible commonly associated diagnoses is encouraged.

2. In those instances when a client is not improving with respect to symptoms, treatment and/or level of functioning related to the current diagnosis, the diagnosis shall be reassessed. The assessment/reassessment process shall actively include the patient and the family (with due consideration for confidentiality).

3. Active assessment of co-morbidity with substance use disorder and/or other psychiatric or medical diagnoses shall occur and be reflected in the client's chart.

4. In assessment of psychosis, providers are encouraged to take into account developmentally normal fantasies, the cultural beliefs of the client and family that may affect the client's sense of reality (such as the belief in spirit possession) and the possibility that the client is resorting to fantasy or imagining other realities due to abuse or other traumas.

5. Prior to establishing a client's diagnosis (or if a diagnosis is in the process of being reviewed), the provider shall integrate into the diagnostic process assessments of the child or youth taken in other settings (i.e. school, daycare, home), including a discussion of symptoms with the client (and their family) as feasible, and an assessment of the child or youth's developmental level.

6. Once a diagnosis has been identified or changed, the child/youth's family or other members of the child/youth's support network shall be provided information about the client's condition and the clinician will initiate discussion of related treatment goals. This diagnostic review and "support team" meeting shall be scheduled as soon as feasible and with appropriate consent. Informing children and adolescents about their condition(s) and involving them in the creation and/or update of their treatment goals is encouraged, occurring with attention to developmental issues, clinical goals, and any anticipated behavioral impact.

7. The client's assessment and chart shall reflect the symptoms of their disorder(s), their impact on the client's functioning, as well as the strengths and resiliencies of the client and their support system and how those strengths and resiliencies can be leveraged to promote the client's recovery. Chart documentation shall also address client goals and integrate client voice as developmentally appropriate.

8. During the assessment process, the provider shall engage the client and their family or support system (separately as feasible) in identifying any traumatic events that the client may have experienced or is experiencing. Providers shall be alert for bias, bullying, abuse, or other traumas, and are encouraged to use trauma-informed instruments when assessing clients. If the client's family system is under stress or experiencing trauma, the provider is encouraged to engage the family in treatment as appropriate, or refer them to additional supports.

9. Providers shall collaborate and consult with other systems (e.g. schools, child welfare, juvenile justice, developmental disabilities, substance use disorder) as needed (with appropriate permissions) in the treatment of youth clients in order to foster multi-system support.

10. Clinicians are encouraged to consider choices in the type of treatment(s) used and how it varies by: age, developmental stage, severity and subtype of illness, chronicity, co-morbid conditions, family and social environment including family history, patient and family treatment preferences, cultural factors and the availability of expertise relevant to the patient's condition. Providers are encouraged to use treatment modalities that are found by research to be effective with the population(s) being served (evidence-based programs or promising practices).

11. Many symptoms and signs of any given mental illness overlap with, or are common in, other mental health disorders. Symptoms shall be considered and ruled out of consideration in the diagnosis of a mental illness if they are due solely to another mental illness, or other diagnosable physical disorders including sleep disorders, eating disorders, other medical problems and/or developmental disorders. Providers shall consider how behaviors and signs of mental illness may also differ significantly by ethnicity/race, spiritual beliefs, community norms and language.

12. Assessment, diagnosis and treatment shall incorporate the ethic and goal of recovery wherever possible.

The DSM-IV-TR and Additional Diagnostic Manuals:
Due to the link between an accurate DSM diagnosis and the Access to Care parameters, all clinicians shall use the DSM-IV-TR (or DSM-V when available) for primary diagnosis.

Providers are encouraged to refer to the AACAP Practice Parameters, the DC03R for children 5 years old and younger, and the ICD-10 as supplemental guides. The ICD-10 may be useful when a client has a diagnosis from the ICD-10 due to previous treatment in another country, when a clinician is working with a refugee or immigrant. In those situations, referring to the client's previous ICD-10 diagnosis may assist in determining an appropriate diagnosis from the DSM-IV-TR for current treatment.

- **Diagnostic and Statistical Manual of Mental Disorders Four: Text Revision (DSM-IV-TR)** (APA, 2000) **Note:** The next edition of the DSM, DSM-5, is scheduled for publication in May 2013. http://www.psych.org/MainMenu/Research/DSMIV/DSMIVTR.aspx

- **American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameters,** http://www.aacap.org/cs/root/member_information/practice_information/practice_parameters/practice_parameters

- **Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, Revised (DC03R),** (Zero to Three, 2005) http://www.zerotothree.org/child-development/early-childhood-mental-health/diagnostic-classification-of-mental-health-and-developmental-disorders-of-infancy-and-early-childhood-revised.html

- **World Health Organization (WHO) International Classification of Diseases (ICD-10),** (www.who.int.classifications/icd)

Guidelines for the Diagnosis of Mental Health Conditions in Children and Youth:

Guidelines for Diagnosing Depressive Disorders in Children
When diagnosing children, providers shall take into account the following: maternal or postnatal depression and the possibility of prenatal exposure to alcohol, tobacco, prescription and non-prescription medications and other intoxicating substances. Providers are encouraged to consider how depression can also be exacerbated by structural inequalities/stressors such as poverty, crime, cultural disintegration, etc.[i]

In the diagnosis of primary depressive mood disorders providers shall refer clients to a medical assessment to rule out depression from medical causes, (e.g. endocrine/hormone disorders, chronic diseases, mononucleosis, anemia, and vitamin deficiency). If any of these causes are present, lack of improvement following treatment for that condition shall lead to further evaluation for mental health treatment.

Although less common, bipolar disorder is an important differential diagnosis that shall be considered. Providers are encouraged to consider the following: In children and adolescents with bipolar disorder, illness can often begin with a major depressive episode. [iiiii] Treatment for depression, particularly medication for depression, can trigger a manic phase. **Severe major depression** in children and adolescents may involve psychosis; auditory hallucinations (often criticizing the patient) rather than delusions (as occur in adults) are more common. This age-related variability in psychotic symptoms may be a result of differences in cognitive maturation. Patients with severe major depression or depression-related psychosis are at a greater risk of suicide. [iv]

Assessment and Treatment shall take into account:

1. The chart shall reflect the need for supervision and disclosure related to the risk of suicide, self-harm, and/or harm to others. These behaviors shall be assessed at intake and re-assessed on an ongoing basis. Suicide risk may occur or persist even when other aspects of the child's depression are improving. The chart shall reflect the need for supervision and disclosure related to the risk of suicide, self-harm and/or harm to others. As suicide risk may occur, persist, or increase even when other aspects of the child's depression are improving, risks shall be assessed at intake and reassessed on an ongoing basis.

2. Behavioral symptoms shall be addressed with the appropriate use of one or more of the following; skills training, parent training, family therapy, client therapy, environmental modifications, psycho-education, supportive management, family/school involvement, psychotherapeutic treatment, medication and/or other treatment modalities as needed and documented. The least restrictive level of treatment shall be used relative to the risk the client holds to self and others.

Guidelines for Attention Deficit Hyperactivity Disorder in Children

When diagnosing children or youth, providers shall consider the possibility of environmental factors via initial and/or ongoing conversations with the family and/or client. Environmental factors may include toxin exposure, family stressors, etc. Studies suggest a potential link between cigarette smoking and alcohol use during pregnancy and ADHD in children. [v]In addition, preschoolers who are exposed to high levels of lead, which can be found in plumbing fixtures or paint in old buildings, may have a higher risk of developing ADHD.[vi]Children who have suffered a brain injury may show behaviors similar to those of ADHD, however, only a small percentage of children with ADHD have suffered a traumatic brain injury. Some behaviors can appear to be ADHD-related, but instead are caused by sudden life changes (such as divorce, a death in the family, or moving), family conflict; or medical disorders affecting brain function.

If environmental factors are involved, providers are encouraged to speak with the client and/or family about reducing or eliminating those factors.

About 20 to 30 percent of children diagnosed with ADHD have a **learning disability** such as dyslexia, or disabilities that involve writing, spelling, or arithmetic.[vii] Providers for children diagnosed with ADHD shall provide information to parents and/or the youth's school on the availability of assessments via the school district to determine if a learning disability exists.

Assessment and Treatment shall take into account:

1. Collaboration with the client's school, including the client's special education plan, as needed.

2. A determination if any medical or developmental issues are influencing ADHD behaviors.

3. Behavioral symptoms shall be addressed with the appropriate use one or more of the following; skills training, parent training, family therapy, client therapy, environmental modifications, and/or other treatment modalities as needed and documented.

Guidelines for Post-Traumatic Stress Disorder in Children

Any child or youth that presents with post-traumatic symptoms shall be assessed for safety concerns; Infants and young children are more vulnerable to maltreatment than older children; 77% of children killed due to maltreatment are under the age of 3 years.[viii] Providers are encouraged to take into account that very young children may have few of the PTSD symptoms we see in adults. This may be because 8 of the 17 PTSD symptoms in the DSM require that the trauma survivor be able to talk about what happened.[ix]

Providers are also encouraged to consider attachment issues. If a child receives attuned, soothing responses from their caregiver when distressed, they learn to develop their own coping skills and might be less likely to experience traumatic reactions after exposure to trauma. **A child with attachment difficulties** could be expected to evidence behavioral difficulties (e.g., aggression, withdrawal).[x]

Symptoms shall be considered and ruled out of consideration in the diagnosis of PTSD if they are due solely to other diagnosable disorders. Clinicians shall take into account that the behaviors and signs of PTSD and trauma exposure may also differ significantly by ethnicity/race, spiritual beliefs, community norms and language.

Assessment and Treatment shall take into account:

1. The client shall be assessed for safety as needed. When necessary, the provider shall communicate risk with legal entities including the Division of Child and Family Services (DCFS), law enforcement and/or Juvenile Justice. All mandatory reporting laws shall be followed.

2. Treatment shall be provided as soon as possible after trauma(s), and documentation will reflect rapid responses, particularly when a trauma is single-episode. When trauma is chronic or repetitive, time may be needed to build trust with the child and their family or support system, and longer-term treatment may be advisable.

3. Clients with PTSD have a higher rate of multi-systems involvement. When the client is engaged in multiple systems, coordination with other agencies shall occur as clinically indicated, using appropriate releases of information.

Guidelines Regarding Oppositional Defiant Disorder in Children

All children are oppositional from time to time, particularly when tired, hungry, stressed or upset. Oppositional behavior is often a normal part of development for two to three year olds and early adolescents. **For children who are diagnosed with Oppositional Defiant Disorder (ODD) using DSM-IV-TR criteria, providers shall note an ongoing pattern of uncooperative, defiant, and hostile behavior toward authority figures that seriously interferes with the youngster's day to day functioning.** [xi]

Providers shall take into account social risk factors for oppositional or conduct disordered behaviors such as; separation from parents, early institutionalization, family neglect, abuse or violence, parents' psychiatric illness, parental marital discord, rejection, and poverty.[xii] Oppositional conduct may also occur in response to bullying or abuse, including exposure to domestic violence. Minority youth, including youth who may be homosexual or bisexual or have divergent gender identities, may have oppositional behaviors due to fear of or experience of bias.

For Children and Youth Diagnosed with ODD or with oppositional behaviors, treatment shall include one or more of the following: parenting programs or parenting interventions to help parents manage the child's behavior, psychotherapy for anger management, family psychotherapy to improve communication and mutual understanding, social skills training to increase flexibility and frustration tolerance with peers, and other types of treatment as required and documented. A child with persistent oppositional behaviors can be very difficult for parents, and providers are encouraged to provide the family with referrals to supportive resources.

At least partially due to the fact that ODD is often diagnosed in youth with other mental health conditions, this diagnosis may not appear in DSM-V, or it may be altered in content. [xiii]

Therefore, when a child with oppositional behaviors presents for diagnosis, providers shall take into account the possibility of alternative diagnoses or co-occurring conditions, such as:

1. ADHD, particularly if oppositional behaviors occur when the child is in situations where maintaining or focusing attention is required.[xiv]
2. Repetitive breaks in the child's caretaker, or primary supports.
3. Signs and symptoms of anxiety and depressive disorders.
4. Stress on the family and/or the child's support network.
5. Learning disorders or developmental disorders (e.g. Autism Spectrum Disorders).
6. Cultural variability in emotional expression, including cultural meanings that may be ascribed to aggression in children or allow it in certain circumstances.
7. Intrauterine exposure to alcohol, tobacco, prescription or illicit drugs.
8. Trauma reactions due to bullying or abuse: providers shall check to see if bullying, abuse, domestic violence or other forms of violence are addressed appropriately in the school and home environments. Above all, providers shall ensure safety by referrals to the police, school and/or child welfare when appropriate.[xv]

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i. Marsella, A.J., Kaplan, A., & Suarez, E. (2002). Cultural considerations for understanding, assessing, and treating depressive experience and disorders. In M. Reinecke & J. Cohler (Eds.) Treatment and assessment of depression. New York:NY: Springer,

ii. Birmaher B, Ryan ND, Williamson DE, Brent DA, Kaufman J, Dahl RE, et al. Childhood and adolescent depression: a review of the past 10 years. Part I. J Am Acad Child Adolesc Psychiatry 1996; 35:1427-39.

iii. Akiskal HS. Developmental pathways to bipolarity: are juvenile onset depressions pre-bipolar? Am Acad Child Adolesc Psychiatry 1995;34:754-63.

iv. Bhatia, S.K. et al (ibid)

v. Mick E, Biederman J, Faraone SV, Sayer J, Kleinman S. Case-control study of attention-deficit hyperactivity disorder and maternal smoking, alcohol use, and drug use during pregnancy. *Journal of the American Academy of Child and Adolescent Psychiatry*, 2002 Apr; 41(4):378-385.

vi. Braun J, Kahn RS, Froehlich T, Auinger P, Lanphear BP. Exposures to environmental toxicants and attention-deficit/hyperactivity disorder in U.S. children. *Environmental Health Perspectives*, 2006 Dec; 114(12):1904-1909.

vii. AACAP, "Practice Parameters for the Assessment and Treatment of Children and Adolescents with Attention Deficit Hyperactivity Disorder" 2007, Journal American Academy of Child and Adolescent Psychiatry, 46:7, July

viii. National Research Council & Institute of Medicine (2000). From neurons to neighborhoods: The science of early childhood development. Washington D.C: National Academy Press.

ix. Barnett, E.R.; Hamblen, J.; "Trauma, PTSD and Attachment in Infants and Young Children," US Department of Veteran's Affairs, 2007 (http://www.ptsd.va.gov)

x. Bowlby, J. (1982). Attachment and loss: Vol. 1. Attachment (2nd ed.). New York: Basic Books (Original work published 1969).

xi. AACAP "Facts for Families: Children with Oppositional Defiant Disorder," No. 72, March 2011

xii. Loeber, R., & Stouthamer-Loeber, M. (1986). Family factors as correlates and predictors of juvenile conduct problems and delinquency. In M. Tonry & N. Morris (Eds.), *Crime and justice* (Vol. 7). Chicago: University of Chicago Press. Cited in: US Public Health Service, "Mental Health, a Report of the Surgeon General," ch. 3 (www.surgeongeneral.gov)

xiii. National Alliance on Mental Illness (NAMI), "NAMI's Comments on the APA's Draft Revision of the DSM-V: Proposed New Diagnosis: Temper Regulation Disorder with Dysphoria" 2011, NAMI (www.nami.org)

xiv. AACAP 2007 (ibid)

xv. Kuban, C.: "Oppositional Defiant Disorder and Trauma," National Institute for Trauma and Loss in Children, (http://www.starrtraining.org)

Diagnosis-Specific Practice Guidelines: Adults/Older Adults

Purpose:
To provide guidelines for appropriate assessment and treatment related to specific diagnoses.

Requirements:
Providers shall enhance diagnostic accuracy and consistency by developing internal policies and procedures that lead to consistency in diagnosis by the mental health professional responsible for the client's care and the provider psychiatrist or ARNP responsible for the client medications, if medications are prescribed. The policies and procedures will also guarantee that the diagnostic information submitted to the KCMHP is consistent with the diagnoses indicated in the clinical chart. Where the guidelines are not felt to be desirable for a particular client, the rationale for not following the guidelines shall be documented in the chart.

Procedures:
Providers shall ensure the following steps are taken:

1. All client diagnoses shall be justified in the chart, using DSM-IV-TR criteria. (Supporting evidence such as family history of mental illness, discussion of cultural factors affecting the differential diagnosis, and review of symptoms to rule out commonly associated diagnoses are encouraged but not required);

2. In those instances when a client is not improving with respect to symptoms and/or functioning linked to the current diagnosis, the diagnosis shall be reassessed;

3. The active consideration of co-morbidity shall occur and shall be reflected in the client's chart;

4. Clients and appropriate members of the client's support network shall be given information about the client's condition medications and possible side effects, when feasible and with client consent. They shall be informed of ways in which the client and support network can manage the client's unique care, both in times of crisis and in times of stabilization and rehabilitation. Information about individualized crisis management shall include how to recognize the client's unique symptoms of decompensation and, should these occur, the specific actions to be taken by the client and support network persons.

5. The diagnosis-specific guidelines are not intended to define intensity or level of care. All services referenced in the guideline are intended to be delivered in a timely manner, with client's needs dictating priority for services.

6. The diagnosis-specific guidelines are not intended to require treatment that runs counter to client choice, client preferences for confidentiality, client safety, or provider treatment recommendations that are deemed more desirable for the individual client.

7. When part of the client's care is provided outside of RSN-funded programs, the provider shall document contact with (or attempts to contact) the outside provider to coordinate care. Should it be apparent that the client is receiving medications from an outside provider that are not appropriate for his/her mental health diagnosis or are ineffective, the client and outside provider will be offered a face-to-face medication consultation by the RSN provider; and

8. As these guidelines focus only on those assessment and treatment issues related to diagnosis, they do not emphasize several other components of an accurate assessment or an effective treatment such as coordination of care for clients receiving services from several systems, vocational rehabilitation services, and monitoring of medication side effects.

Recommended Guidelines for Bipolar I

1. The individual service plan (ISP) includes an individualized strategy to prevent manic and depressive episodes. The strategy includes assisting the client and support persons in recognizing early signs and symptoms of an episode, adhering to the ISP (including taking prescribed medication), and accessing timely assistance. The episode prevention strategy is updated as needed.

2. A mood stabilizer is prescribed. Lab monitoring occurs, if clinically indicated. Also see guideline for persons taking an atypical antipsychotic medication.

3. Suicide risk is assessed at intake and when signs, symptoms, or circumstances change such that the client is at increased risk. If significant risk is present, the ISP is changed to provide the appropriate level of services and/or supervision.

Recommended Guidelines for Mental Illness with Substance Use Disorder

1. The ISP includes an individualized strategy to prevent a relapse of the substance use disorder. The strategy includes assisting the client and support persons in recognizing early signs and symptoms of a relapse, adhering to the ISP (including taking prescribed medication), and accessing timely assistance. The relapse prevention strategy is updated as needed.

2. Needed and beneficial mental illness treatment is not withheld simply because of a substance use disorder or the client's refusal of treatment for the substance use disorder.

3. Medications with abuse potential are avoided or aggressively monitored. However, needed psychiatric medications are not withheld simply because of the substance use disorder, unless it is documented that the risks of prescribing the medication outweigh the benefits.

4. If the client is referred to the substance use disorder treatment system, the treatment is coordinated.

Recommended Guidelines for Schizophrenia

1. The ISP includes a strategy to prevent psychotic episodes. The strategy includes assisting the client and support persons in recognizing early signs and symptoms of an episode, adhering to the ISP (including taking prescribed medication), and accessing timely assistance. The episode prevention strategy is updated as needed.

2. The ISP includes the prescription of antipsychotic medication. All clients who have been unable to benefit from or to tolerate other antipsychotic medications shall be considered for clozapine.

3. The client shall be monitored for side effects and/or medication non-compliance. Should these problems occur, there will be a plan to address them.

4. For persons at risk of tardive dyskinesia, there is ongoing assessment for involuntary movements.

5. See guideline for persons taking an atypical antipsychotic medication.

Recommended Guidelines for Major Depression

1. Suicide risk is assessed at intake and when signs, symptoms or circumstances change such that the client is at increased risk. If significant risk is present, the ISP is changed to provide the appropriate level of services and/or supervision.

2. The ISP includes the prescription of antidepressant medications. If a client is not responsive to the medication after 6 to 12 weeks, a change of medication or ECT is considered.

3. The ISP includes psychotherapy. If a client is not responsive to psychotherapy after 6 to 12 weeks, a change in the type of psychotherapy is considered.

Additional Practice Guideline: All Age Groups

Recommended Guidelines for All Persons Taking an Atypical Antipsychotic

Purpose:
To minimize metabolic side effects from atypical antipsychotic medications.

Requirements:
For persons taking atypical antipsychotics, there is annual screening for cardiovascular risk variables (including weight gain, hypertension, serum lipids, serum glucose or A1c, smoking status, and any change over the year in cardiovascular health).

[i] Marsella, A.J., Kaplan, A., & Suarez, E. (2002). Cultural considerations for understanding, assessing, and treating depressive experience and disorders. In M. Reinecke & J. Cohler (Eds.) Treatment and assessment of depression. New York:NY: Springer,

[ii] Birmaher B, Ryan ND, Williamson DE, Brent DA, Kaufman J, Dahl RE, et al. Childhood and adolescent depression: a review of the past 10 years. Part I. J Am Acad Child Adolesc Psychiatry 1996; 35:1427-39.

[iii] Akiskal HS. Developmental pathways to bipolarity: are juvenile onset depressions pre-bipolar? Am Acad Child Adolesc Psychiatry 1995;34:754-63.

[iv] Bhatia, S.K. et al (ibid)

[v] Mick E, Biederman J, Faraone SV, Sayer J, Kleinman S. Case-control study of attention-deficit hyperactivity disorder and maternal smoking, alcohol use, and drug use during pregnancy. *Journal of the American Academy of Child and Adolescent Psychiatry*, 2002 Apr; 41(4):378-385.

[vi] Braun J, Kahn RS, Froehlich T, Auinger P, Lanphear BP. Exposures to environmental toxicants and attention-deficit/hyperactivity disorder in U.S. children. *Environmental Health Perspectives*, 2006 Dec; 114(12):1904-1909.

[vii] AACAP, "Practice Parameters for the Assessment and Treatment of Children and Adolescents with Attention Deficit Hyperactivity Disorder" 2007, Journal American Academy of Child and Adolescent Psychiatry, 46:7, July

[viii] National Research Council & Institute of Medicine (2000). From neurons to neighborhoods: The science of early childhood development. Washington D.C: National Academy Press.

[ix] Barnett, E.R.; Hamblen, J.; "Trauma, PTSD and Attachment in Infants and Young Children," US Department of Veteran's Affairs, 2007 (http://www.ptsd.va.gov)

[x] Bowlby, J. (1982). Attachment and loss: Vol. 1. Attachment (2nd ed.). New York: Basic Books (Original work published 1969).

[xi] AACAP "Facts for Families: Children with Oppositional Defiant Disorder," No. 72, March 2011

[xii] Loeber, R., & Stouthamer-Loeber, M. (1986). Family factors as correlates and predictors of juvenile conduct problems and delinquency. In M. Tonry & N. Morris (Eds.), *Crime and justice* (Vol. 7). Chicago: University of Chicago Press. Cited in: US Public Health Service, "Mental Health, a Report of the Surgeon General," ch. 3 (www.surgeongeneral.gov)

[xiii] National Alliance on Mental Illness (NAMI), "NAMI's Comments on the APA's Draft Revision of the DSM-V: Proposed New Diagnosis: Temper Regulation Disorder with Dysphoria" 2011, NAMI (www.nami.org)

[xiv] AACAP 2007 (ibid)

[xv] Kuban, C.: "Oppositional Defiant Disorder and Trauma," National Institute for Trauma and Loss in Children, (http://www.starrtraining.org)

Additional Signs and Symptoms of Mental Health Disorders in Children and Youth

Observed Behaviors or Signs That May Be Associated with **Depression** in Children and Adolescents:

Symptoms of depressive disorders in children and youth may vary from symptoms seen in adults. Symptoms can also vary significantly by culture and other factors. In addition to the DSM-IV-TR, AACAP Practice Parameters and other guidelines, providers are encouraged to refer to the summary below to help identify children and youth experiencing depressive disorders.

Symptoms of depression in children and adolescents:

- Frequent physical complaints such as headaches, muscle aches, or stomachaches[iii]
- Frequent absences from school, or poor performance
- Alcohol or substance use[iii]
- Reckless behavior, aggression, defiance, stress, anger, hostility[iv] or homicidal impulses[v]
- Belief by family and/or youth that the youth is "evil," "cursed," or somehow marred[vi]
- A belief that they are being punished by God or other spiritual forces for doing something wrong, or because someone has 'cursed' them or wished them ill[viiviii]
- Developmental changes or regressions not due to other causes
- The attribution of negative influences to generally neutral or positive events or persons[ix]
- Increased reactivity to events, such as an elevated startle response or restlessness[x]
- Increased difficulties in communicating
- Change in behavior at home and/or in social relationships
- Repetitive or ruminative thought patterns
- Disengagement from cultural, spiritual, or community activities, or abrupt changes in spiritual beliefs/practices[xixii]
- Self-harm, e.g. cutting skin, burning, or high use of stimulating/depressing activities
- Vague speech, unusual perceptions, or inappropriate affect not due to other causes[xiiixiv]
- Suicidality, in addition to thoughts of death or suicide, can take the form of withdrawal, other negative thought/speech, and giving away possessions. [xv]
- Children and youth who have had a suicide in their community or family are often at higher risk for suicide attempts and completions.

Observed Behaviors or Signs That May Be Associated with **ADHD** in Children and Adolescents:

Symptoms of attention-deficit and hyperactivity disorders may vary from symptoms seen in adults. In addition to the DSM-IV-TR, AACAP and other guidelines, refer to the list below to help identify children and youth experiencing ADHD and related disorders.

Symptoms of ADHD in Children and Adolescents:

- Squirms and fidgets
- Often talks excessively
- Interrupts or intrudes on others.
- Does not finish tasks.
- Has difficulty focusing on one thing
- Has difficulty focusing attention on organizing and completing a task or learning something new
- Has trouble completing or turning in homework assignments, often losing things (e.g., pencils, toys, assignments) needed to complete tasks or activities
- Does not seem to listen when spoken to
- Has difficulty processing information as quickly and accurately as others
- Struggles to follow instructions.
- Blurts out inappropriate comments, shows their emotions without restraint, and acts without regard for consequences
- Has difficulty waiting for things they want or waiting their turns in games
- Has reduced self-control and obedience, particularly when self-control is called for[xvi]
- Adults describe children as having "bad manners" or as being difficult to control[xvii]

The DSM diagnosis for ADHD has three subtypes; inattentive, hyperactive and impulsive (see DSM for the diagnostic guidelines of these subtypes.) Parents and teachers can miss the fact that some children, often girls, with symptoms of **inattention** have the disorder because they are often quiet and less likely to act out. They may sit quietly, seeming to work, but they are often not paying attention to what they are doing. Children with the inattentive kind of ADHD are not the only ones whose disorders can be missed. For example, adults may think that children with the **hyperactive** and **impulsive** subtypes solely have emotional or disciplinary problems.[xviii]

Observed Behaviors or Signs That May Be Associated with **PTSD** in Children and Adolescents:

Symptoms of PTSD and traumatic disorders may vary from symptoms seen in adults. Symptoms in children and youth can also vary significantly by culture and other factors. In addition to the DSM-IV-TR, AACAP and other guidelines, refer to the list below to help identify children and youth experiencing PTSD and related disorders.

A child with PTSD may re-experience the traumatic event by:

- Having frequent memories of the event, or in young children, play in which some or all of the trauma is repeated over and over
- Having upsetting and frightening dreams
- Acting or feeling like the experience is happening again
- Developing repeated physical or emotional symptoms that remind the child of the event [xix]

Symptoms of PTSD in Children and Adolescents:

- Frequent physical complaints such as headaches, muscle aches, or stomachaches
- Reckless behavior or defiance
- Developmental changes or regressions not due to other causes
- Change in behavior at home and/or in relationships with others
- Estrangement or isolation, particularly for community- oriented youth that had traumatic events in their family and/or community. Community-based traumas may include both present and intergenerational traumas[xxxxi]
- Increased irritability, stress, anger, or hostility
- Worry about dying at an early age
- Loss of interest in activities
- Increase in sudden and extreme emotional reactions
- Problems falling or staying asleep
- Changes in eating or weight
- Problems concentrating
- Acting younger than their age (for example, clingy or whiny behavior, thumb sucking) or other developmental regressions not due to other factors
- Increased alertness to the environment and increased reactiveness to everyday events
- Repeating behavior that reminds them of the trauma, such as harm to self or to others[xxii]
- Avoiding places or people that remind them of the traumatic event(s)[xxiii]
- Lost memories or "blank spots" in one's memory corresponding to times in which trauma occurred, and/or lowered ability to feel emotions[xxiv]

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[i] Kramer, E.J.; Kwong, K.; Lee, E.; Chung, H.; "Cultural Factors Influencing the Mental Health of Asian Americans," in Culture and Medicine, Vol. 176, September 2002, 227-231

[ii] Bhatia, S.K.; Bhatia, S.C. "Childhood and Adolescent Depression," American Family Physician (www.aafp.org), 2007, American Academy of Family Physicians

[iii] Shore, J.H. et al (ibid)

[iv] Agbayani-Siewert, P.; Takeuchi, D.T.; Pangan, R.W. "Mental Illness in a Multicultural Context" in Handbook of the Sociology of Mental Health, Ed. Carol Aneshensel and Jo C. Phelan, Kluwer/Plenum Publishers, New York 1999, ch. 2

[v] American Association of Child and Adolescent Psychiatry (AACAP), 2007, Journal American Academy of Child and Adolescent Psychiatry, 46:11, November

[vi] Kramer, E.J. et al. (ibid)

[vii] Miller, K.E.; Omidian, P.; Quraishy, A.S.; Quraishy, N.; Nasiry, M.N.; Nasiry, S.; Kayar, N.M.; Yaqubi, A.A.; "The Afghan Symptom Checklist: A Culturally Grounded Approach to Mental Health Assessment in a Conflict Zone" American Journal of Orthopsychiatry, 2006, Vol. 76, No. 4, 423-433

[viii] Nicolas, G.G.; Desilva, A.M.; Subrebost, K.L.; Breland-Noble, A.; Gonzalez-Eastep, D.; Manning, N.; Prosper, V.; Prater, K.; "Expression and Treatment of Depression among Haitian Immigrant Women in the United States: Clinical Observations" in American Journal of Psychotherapy, Vol. 61, No. 1 2007, p.83-98

[ix] Kramer, E.J. et al. (ibid)

[x] AACAP (ibid)

[xi] Miller, K.E. et al. (ibid)

[xii] Nicolas, G. et al (ibid)

[xiii] Neighbors, H.W.; Trierweiler, S.J.; Ford, B.C.; Muroff, J.R. "Racial Differences in DSM Diagnosis Using a Semi-Structured Instrument: The Importance of Clinical Judgment in the Diagnosis of African Americans" in Journal of Health and Social Behavior 2003, vol. 43 (September): 237-256

[xiv] Shore, J.H. et al (ibid)

[xv] Weller EB, Weller RA, Danielyan AK. Mood disorders in adolescents. In: Wiener JM, Dulcan MK, eds. Textbook of Child and Adolescent Psychiatry. 3rd ed. Washington, D.C.: American Psychiatric Publishing, 2004:437-81.

[xvi] Cho, S., Hwang, J., Lyoo, I., Yoo, H., Kin, B., & Kim, J. (2008). Patterns of temperament and character in a clinical sample of Korean children with attention-deficit hyperactivity disorder. *Psychiatry and Clinical Neurosciences*, *62*(2), 160-166. doi:10.1111/j.1440- 1819.2008.01749.x

[xvii] Rohde, L.A. "ADHD in Brazil: The DSM-IV Criteria in a Culturally Different Population" in Journal of American Academy of Child and Adolescent Psychiatry, 41:9, September 2002, pp. 1131-1133

[xviii] National Institutes of Mental Health (NIMH), Attention Deficit Hyperactivity Disorder, USHHS, Washington DC, 2008

[xix] AACAP "Facts for Families: Posttraumatic Stress Disorder," no. 70, March 201, Washington DC

[xx] Perilla, J.L.; Norris, F.H.; Lavizzo, E.A. "Ethnicity, Culture and Disaster Response: Identifying and Explaining Ethnic Differences in PTSD Six Months After Hurricane Andrew" in Journal of Social and Clinical Psychology, Vol. 21, No.1, 2002, pp.20-45

[xxi] Allen , I. (1996). PTSD among African Americans. In A. Marsella, M. Friedman, E. Gerrity,

& R.Scurfield (Eds.). *Ethnocultural aspects of PTSD: Issues, research, and clinical applications*.

Washington, DC: American Psychological Association.

[xxii] Famularo, R. "What are the Symptoms, Causes and Treatments of Childhood Post-Traumatic Stress Disorder" Harvard Mental Health Letter, January 1997

[xxiii] Centre for Addiction and Mental Health Canada, "Information on Post-Traumatic Stress Disorder (PTSD) for Refugees and New Immigrants," April 2011, CAMH (http://www.camh.net)

[xxiv] CAMH 2011 (ibid)

Recommendations Regarding Medication Prescription and Monitoring for Children

In prescribing children and youth medication for their clinical condition(s), the following issues need to be considered and addressed by the prescriber and the client's clinician:

Any child or youth receiving a psychiatric medication needs to be monitored by the child's counselor and psychiatric provider for any adverse reactions or effects.[i]

1. Those receiving stimulant medications for ADHD should have their height and weight monitored for possible effects on growth.[ii] When considering use of stimulant medications youth and parents should be asked about any history of cardiac abnormalities. If such a history is present refer the client for medical evaluation and clearance prior to initiating stimulant treatment. Obtaining a blood pressure assessment from the prescriber or agency nurse prior to stimulant treatment is desirable.

2. Anti-psychotic medications are prescribed for both psychosis and mood disorders, and used for short or long periods of time. Use of anti-psychotics may lead to extrapyramidal symptoms (EPS) which can be an ongoing effect if the medication is not modified. For children receiving long-term antipsychotic medications, there should be an annual screening for cardiovascular risk variables (including weight gain, hypertension, serum lipids, serum glucose or A1c, smoking status, and any change over the year in cardiovascular health).

3. Ongoing communication between non-medical staff and prescribers is critical. If there are differences in diagnosis for a particular patient, prescribers and non-medical staff should communicate to resolve diagnostic differences. Such communications and their results should be documented in the patient's records. When part of the client's care is provided outside of RSN-funded programs, the provider shall document communication with the outside provider(s) to coordinate diagnostic understanding and care. If the outside provider has a different diagnostic assessment then the agency staff, then a meeting or other conversation to resolve differences in diagnosis should be arranged and the results documented in the patient file.

[i] American Family Physician 2007;75:73-80, 83-4, 2007 American Academy of Family Physicians

[ii] AACAP 2007 (ibid)

Guidelines for Psychiatric Consultation and Evaluation

Purpose:
To provide guidelines for psychiatric consultation, evaluation, and services under the RSN/KCMHP.

Requirements:
All providers shall develop and implement policies and procedures to support these guidelines. The provider's medical director (or lead psychiatrist) and clinical director (or lead clinician) must approve the provider policies and procedures.

Clinical Standards:
The guidelines shall ensure, at a minimum, that all KCMHP clients:

1. Are initially and periodically screened for a need for psychiatric consultation, evaluation and/or medications;

2. Have timely access to a medication appointment (with a psychiatrist or ARNP), whenever an emergency medication appointment is indicated; and

3. Have a specific medication appointment (with a psychiatrist or ARNP) in place at the time of discharge from the hospital, with the appointment and the name of the prescriber made available to the hospital prior to discharge so that an inpatient-to-outpatient prescriber phone consultation is possible if requested by the hospital.

Wraparound Practice Guidelines

Purpose:
To provide guidelines for best practice implementation of the wraparound process for outpatient providers who are serving clients not enrolled in MIDD Wraparound.

Target Population:
Children and adolescents from birth up to age 21 who are receiving mental health services funded in whole or in part by the RSN/KCMHP, who are authorized for a 3B case rate, and who are involved with at least one other child-serving system.

Expected System Outcomes:
It is expected that by implementing a high-quality wraparound service model children and youth will demonstrate improved functioning at home, school/work, and within the community and will be maintained within their home and community environments, decreasing the utilization of more restrictive placements such as inpatient hospitalization, residential placement, or juvenile justice involvement. Additionally, the implementation of the wraparound service model will allow providers to meet the goals that the family has set for itself while evolving to the point where the family is empowered to engage more informal community supports.

Requirements:
Providers shall improve quality and consistency in the implementation of the wraparound process for children, youth, and families by developing internal policies and procedures that lead to the integration of the Ten Principles of the Wraparound Process, as described below, into service provision. The policies and procedures will also ensure that the wraparound process consistently follows the phases and activities detailed in the guidelines. When the guidelines are not followed for a particular client, the rationale for not following the guidelines shall be documented in the chart.

Ten Principles of the Wraparound Process:
Providers shall ensure that all staff provides services in accordance with the Ten Principles of the Wraparound Process:

1. Family voice and choice: Ensure that the needs and priorities of the family determine how and when services are rendered, and that the intervention goals and desired outcomes are mutually defined with the family and youth. Family and youth/child perspectives are intentionally elicited and prioritized during all phases of the wraparound process. Planning is grounded in family members' perspectives, and the team strives to provide options and choices such that the plan reflects family values and preferences;

2. Team-based: The wraparound team consists of individuals committed to the family and youth through informal, formal, and community support and service relationships. The family and youth will agree on all team members;

3. Natural supports: The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships. The wraparound plan reflects activities and interventions that draw on sources of natural support;

4. Collaboration: All team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single wraparound plan. The plan reflects a blending of team members' perspectives, mandates, and resources. The plan guides and coordinates each team member's work towards meeting the team's goals;

5. Community-based: The wraparound team implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible; and that safely promote child and family integration into home and community life;

6. Culturally competent: The wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the child/youth and family, and their community;

7. Individualized: To achieve the goals laid out in the wraparound plan, the team utilizes the particular strengths, assets, resources, and needs of the youth and family to develop and implement a customized set of strategies, supports, and services;

8. Strengths-based: The wraparound process and the wraparound plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members;

9. Persistence: Despite challenges, the team persists in working toward the goals included in the wraparound plan until the team reaches agreement that formal wraparound support is no longer required and eventually evolving into a team of community support; and

10. Outcome-based: The team ties the goals and strategies of the wraparound care plan to observable and measurable indicators of success, monitors progress in terms of these indicators, and revises the plan as necessary.

Recommended Guidelines for the Wraparound Process:

The activities and phases described below are recommended as critical and necessary components for the implementation of high quality wraparound. The activities identify a facilitator as responsible for guiding, motivating, or undertaking the various activities. This is not meant to imply that a single person must facilitate all of the activities. The various activities may be split up among a number of different people. For example, on many teams, a parent partner or advocate takes responsibility for some activities associated with family and youth engagement, while a facilitator is responsible for other activities. On other teams, a facilitator takes on most of the facilitation activities with specific tasks or responsibilities taken on by a parent, youth, and/or other team members. In addition, facilitation of wraparound team work may transition between individuals over time, such as from a facilitator to a parent, family member, or other natural support person, during the course of a wraparound process.

Families, as defined by the wraparound process, may be a single biological or adoptive parent and child or youth, or may include grandparents and other extended family members as part of the central family group. If the court has assigned custody of the child or youth to some public agency (e.g., child protective services or juvenile justice), the caregiver in the permanency setting and/or another person designated by that agency (e.g. foster parent, social worker, probation officer) takes on some or all of the roles and responsibilities of a parent for that child and shares in selecting the team and prioritizing objectives and options. As youth become more mature and independent, they begin to make more of their own decisions, including inviting members to join the team and guiding aspects of the wraparound process.

The use of numbering for the phases and activities described below is not meant to imply that the activities must invariably be carried out in a specific order, or that one activity or phase must be finished before another can be started. Instead, the numbering and ordering is meant to convey an overall flow of activity and attention. For example, focus on transition activities is most apparent during the latter portions of the wraparound process; however, attention to transition issues begins with the earliest activities in a wraparound process.

Phase I Engagement and team preparation:

During this phase, the critical components and elements of the wraparound process are initiated. The family and youth are oriented to the wraparound process. The foundation of wraparound is built around the essential characteristics of the family and youth. In some situations, this may happen prior to the formal beginning of wraparound services.

1.1 Orient the family and youth to wraparound: The facilitator describes in detail the wraparound process and what level of participation is needed from each member of the group. The facilitator actively works to engage the family and youth in the wraparound process.

1.2 Address pressing needs and concerns: The family and facilitator identify the immediate needs in a way that provides for present and future stability. Any skills that need to be acquired to meet future needs may be identified at this time and used in the development of the wraparound care plan.

1.3 Explore strengths, needs, culture and vision with child and family: The facilitator leads the family through a process of identifying strengths of individual members and the family as a whole. The facilitator gathers information from the family in regards to the identified culture, values, and the vision the family has for itself. Goals and tasks of the wraparound care plan will be based on strengths and aligned to the family vision. Outcomes will be based on progress toward this vision.

1.4 Solicit participation of team members, build team cohesion: The family and facilitator work together to identify potential team members and decide how to illicit their participation. The facilitator and family work to ensure representatives from all systems involved with the family participate on the team. This might require exploring options regarding who is the most appropriate member of each system to attend. Peer counselors may be utilized in this process.

1.5 Arrange meeting logistics: Meetings should be arranged at a time and location convenient to the family. This may mean meetings outside of regular business hours at locations in the community which are easily accessible and convenient to the family.

Phase 2 Initial plan development:

During this phase, the team works to develop the initial wraparound care plan. This care plan should utilize existing strengths and identify skills that need to be developed over the course of care. The plan should be developed with the ultimate goal of transitioning to informal and community supports.

2.1 Identify goals and tasks of the wraparound care plan: The team identifies goals and tasks needed to help the family move toward its vision and sets appropriate timeframes for completion of each task. The wraparound care plan uses existing strengths and builds skills needed to accomplish goals. The wraparound care plan addresses the family's transition into the community and informal supports.

2.2 Develop a crisis prevention plan: The team works together to create a crisis prevention plan that utilizes community and natural supports as well as formal services to resolve a crisis as quickly as

possible at the least restrictive level of intervention. The plan should also incorporate strategies to prevent future crises. Any skills needed to resolve or prevent future crises should be identified and incorporated into the overall wraparound care plan.

Phase 3 Implementation:

During this phase, the initial wraparound care plan is implemented, progress and successes are continually reviewed and changes to the wraparound care plan are made as needed. The activities of this phase are repeated until sufficient progress toward the goals identified in the wraparound care plan is made and the family is empowered to transition to less formal supports.

3.1 Implementation of the wraparound care plan: For each goal in the wraparound care plan, team members assume responsibility for tasks. Tasks should be shared amongst team members.

3.2 Track progress and evaluate successes: At each meeting, the team evaluates and monitors progress toward existing goals and modifies or adds any new goals identified by the team.

3.3 Increase and strengthen informal and community supports: New members may be added to the team to reflect identified post-transition goals, services, and supports. The team discusses and plans for responses to potential future situations, including crises, and negotiates the nature of each team member's post-wraparound participation with the team/family.

3.4 Maintain team cohesiveness and trust: The facilitator helps the team to maintain cohesiveness and satisfaction by continually educating team members – including new team members – about wraparound principles and activities. The team shares the responsibility of open communication, active problem-solving, and ensuring adherence to the values and principles of wraparound.

Phase 4 Transition:

As the implementation of the wraparound care plan evolves and progress toward goals is achieved, the team moves toward a purposeful transition where the family is empowered to engage more informal community supports.

4.1 Empower informal and/ or community supports to take on increasing leadership of the team: The facilitator and team work to identify an informal or community support person or persons to facilitate the team process. First consideration should always be given to the family, caregiver, or youth. This process may begin during the implementation phase through shared responsibility for leadership of the team.

4.2 Implement transition to informal supports: The team is continually supporting a natural progression from a team of formal support and service professionals to a team made up largely of community and natural supports. The family and youth are empowered to utilize their natural support systems to assist in skill building and resource gathering. The team reviews strengths and needs and identifies services and supports that can meet the needs that will best serve the youth and family beyond the formal wraparound team.

4.3 Ongoing process: As determined by the family, the team of natural and community supports continues to meet and support the family on an ongoing basis. To ensure that the family is continuing to experience success in meeting its goals, the team develops a procedure that empowers the family to identify and access appropriate services when needed. This may include inviting formal services to join the ongoing team to address a specific need or goal.

These guidelines meet the state DSHS contracted mandate for practice parameters in accordance with the Balanced Budget Act.

For further detail regarding the phases and activities of the wraparound process, please refer to the following references:

Walker, J.S., Bruns, E.J., VanDenBerg, J.D., Rast, J., Osher, T.W., Miles, P., Adams, J., & National Wraparound Initiative Advisory Group (2004). *Phases and activities of the wraparound process.* Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University; and

Bruns, E.J., Walker, J.S., Adams, J., Miles, P., Osher, T.W., Rast, J., VanDenBerg, J.D. & National Wraparound Initiative Advisory Group (2004). *Ten principles of the wraparound process.* Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University.

Both documents can be accessed at the National Wraparound Initiative website at: www.rtc.pdx.edu/nwi

Developmental Practice Guidelines for Children ages 0-21

Purpose:
To provide guidelines to enhance developmentally appropriate assessments and developmentally appropriate treatment of children and youth in accordance with the King County Recovery Plan.

Service Population:
Children and adolescents from birth to age 21 who are receiving mental health services funded in whole or in part by the KCMHP.

Expected Outcomes:
The goal is to increase clinician conceptualization and understanding of symptom expression of a mental health issue in children and adolescents within the context of their developmental status. The utilization of the developmental guidelines by clinicians will help to expand the clinical repertoire/rationale in treatment planning to include developmental support as a foundation of effective clinical treatment including a focus on restoration of a healthy developmental process.

Requirements:
Providers shall enhance assessment and treatment by developing internal policies and procedures that lead to the application of the Developmental Stages Guidelines by the mental health professional responsible for the client's care. When the guidelines are not felt to be desirable for a particular client, the rationale for not following the guidelines shall be documented in the client's chart.

Recommended Guidelines for Developmental Stages:
Using the Developmental Stages Grid available on the King County website at http://mhd-intranet/downloads.html#devguide as a guide, providers shall ensure the following steps are taken:

1. Provision of a developmental assessment that includes consideration of chronological age, any disabilities or other factors effecting capacity for meeting normative developmental landmarks, and relationship/social accomplishments.

2. Formulation of the child/adolescent's clinical presentation and individual service plan in a way that reflects an understanding of the difference between symptomology and normative development. (i.e., a teenager "rebelling" typically is an expression of normative development – an intervention would be to help the child "rebel" in a safer way).

3. Formulation of the child/adolescent's clinical presentation and individual service plan in a way that reflects an understanding that expression of psychiatric disorders in children and youth may reflect their developmental status. (Rather than express sadness and suicidal ideation as do many adults who are depressed, a child may behave in a way that is angry and self destructive.)

4. Formulation of how the child's clinical issues may have created deviations from normative developmental progress. Restoration of typical developmental process, including support of parents, shall be incorporated into the individual service plan along with symptom reduction (recovery-oriented services).

    - Assessments shall reflect consideration of developmental deviations as well as classic symptomology.

- Treatment interventions shall include attention to completion of developmental tasks (e.g., increased decision making, problem-solving ability, moving away from parents, etc.). (A depressed teenager stays at home playing on his computer. Engaging his mother in rule-setting on how long he can be on the computer and demanding he do more healthy activities – with treatment he rekindles an interest in basketball and re-engages with friends.)

5. Formulation of how a child's clinical issues may be the result of such issues preventing a normal developmental process. (A child has complex learning disabilities despite somewhat above-average intelligence and is not developing judgment and impulse control commensurate with his age and intelligence, due to Fetal Alcohol Spectrum Disorder.)

6. Educate parent/caregivers and child/adolescent clients about normative developmental process and help them adapt as the child grows.

7. Assist parent/caregivers to examine their expectations within the child's developmental capacities and to make meaning of the child and family's experiences as part of the developmental process.

8. Appropriate members of a child or adolescent's support network shall be given information about the client's condition and subsequent management issues. Informing children and adolescents about their condition and involving them in their Individual Service Plans (ISPs) is desirable, but should be accomplished through developmentally appropriate means and with sensitivity to timing.

9. The developmental guidelines are not intended to define intensity or level of care. All services referenced in the guidelines are intended to be delivered in a timely manner, with client's needs dictating priority for services.

10. The developmental guidelines are not intended to require treatment that runs counter to client choice, client preferences for confidentiality, client safety or provider treatment recommendations that are deemed more desirable for the individual client.

11. Where guidelines are not followed because part of the client's care is provided outside of RSN-funded programs, the provider shall document that the guidelines are not being met, even if not directly providing that part of the care. Additionally, the provider shall discuss the guideline with the non-RSN provider, and, for a client who is not benefiting fully from his ISP, the provider shall offer a revised plan. For clients with non-RSN-funded prescribers, the revised plan shall include a prescriber-to-provider review of medication guidelines and an offer to the client for prescription services with the KCMHP provider.

12. As these guidelines focus only on those assessment and treatment issues related to developmental progress, they do not emphasize several other components of an accurate assessment or an effective treatment such as coordination of care for children receiving services from several systems and monitoring of medication side effects. Any therapy for children needs to be appropriate for the developmental level of the child.

Practice Protocols for Peer Support

Purpose:
As a guide to increase understanding, reduce confusion, and provide a path to successful integration of peer support specialists in the delivery of quality services. Peer Standards were originally developed in 2007 in response to requests from local mental health agencies who were seeking guidance on how to incorporate peer services into their current array of services. This 2013 retitled revision was informed by the national Pillars for Peer Support Services (2009, 2010, 2011, and 2012) and the 2009 Clark County Peer Support Guidelines. These protocols were developed in a robust process with input from community mental health agency and MHCADSD staff including administration, supervisors, and peer support specialists as well as community stakeholders.

Expected System Outcomes:
The desired outcome is a clearer understanding of the roles, responsibilities, and value of peer support specialists working within an agency setting, and the achievement of a mutually respectful, cohesive, and effective working relationship for peers and non-peers within the mental health system. The ultimate goal is better outcomes for the people receiving services.

Provider agencies that integrate peer support specialists into their workforces find that they have a heightened awareness of the struggles faced by the people they are serving. Stigma is often reduced as negative attitudes toward people living with mental health and behavioral health challenges shift. Peer Support Specialists who work alongside other professional non-peer clinicians provide living proof that recovery is possible. This can raise morale by providing evidence to service providers that people are resilient and can (and do) recover. Peers' personal experiences can be a valuable asset to the clinical team. When they add their first-person knowledge and their stories of recovery to the service mix, services are enhanced and extended, as well as infused with hope and self-determination.

Definitions:
Certified peer counselors – Are self-identified consumers of mental health services (including parents or caretakers of children and youth with mental health challenges) who have completed specialized training provided or contracted by the Washington State Division of Behavioral Health and Recovery (DBHR) and have successfully passed an examination administered by DBHR or an authorized contractor. Once employed by an agency, they must register with the Washington State Department of Health as an Agency Affiliated Counselor.

Implementation guidelines – Are offered as suggestions for each Protocol and should be adapted to fit the unique needs of each agency or program. The guidelines can be a demonstration that the Protocol has been achieved, as in “You’ll know you’ve achieved this Protocol when…” If an agency meets the Protocols in ways other than those suggested by the guidelines, the methods must be articulated in agency policy and procedures.

Paraprofessional peer specialists – Are self-identified consumers of mental health services, including people with legal histories, who may be unable to become certified peer counselors because they have barriers to being approved as an Agency Affiliated Counselor or who have other barriers to becoming certified. Because of their own experience, these paraprofessional peers can share their strength and hope in their decision to stay in recovery even when they are challenged with the barriers of the legal system. These barriers can cause some consumers to be concerned that their own recovery process has

stalled. Paraprofessional peers can support consumers through the process and encourage endurance during that crucial period when the legal system and such a history appears to prevent advancement.

Parent Partners – Parents or caretakers of a child who has had a history of mental health and/or behavioral issues and an experience of recovery and resiliency and who have completed training in providing peer support to families.

Peer support – The process of giving and receiving non-clinical assistance to achieve long-term recovery from severe psychiatric, traumatic or addiction challenges. This support is provided by peer supporters - people who have "lived experience" and have been trained to assist others in initiating and maintaining long-term recovery and enhancing the quality of life for individuals and their families.

Peer support specialists – Persons who are trained to provide peer support. They may be certified peer counselors or paraprofessional peers. Note that the Washington State Plan service modality titled "peer support" funded by Medicaid must be provided by certified peer counselors. All peer support specialists can provide other service modalities (excluding intake, integrated COD screening, medication management, and some other specialty services). Peer support specialists may be paid or in volunteer or internship positions. Peer support specialists include:

1. Adults and youth who have a history of mental illness who also have a personal experience of recovery and resiliency,

2. Parent partners, and

3. Same-age peers working with older adults.

Same-age peers – Are persons trained to provide recovery and resiliency support services to older adults. These same-age peers need not necessarily have a lived experience of recovery, as many older adults do not see themselves as having a mental illness. Their need may be more for companionship as they build resiliency and attend to the tasks of aging, including life review, health concerns, and adjusting to loss. Same-age peers are considered paraprofessional peer specialists.

Protocols – Are universal requirements. Each of 14 Protocols includes a description and implementation guidelines. Several of the Protocols touch on hiring practices and other issues usually handled by human resources. It will be important to share this work with agency HR staff and to work together towards implementation of each of the Protocols in a manner that fits with agency policies, and in context with all state, federal, and other regulatory guidelines. A number of the Protocols and Guidelines express policies and procedures that are usual and customary for all staff. Because some peers report their experience of agency employment differs from usual human resource policies and procedures, these expectations are reiterated in the Protocols. The Protocols include:

1. Valuing the provision of peer support services in community mental health settings

2. Integrating peer support specialists into the culture of each agency

3. Providing peer support within teams and promoting their integration as valued team members

4. Respecting shared experiences as the foundation of peer support

5. Ensuring clear employment practices for peer support specialists, including recruitment, job descriptions, orientation, and opportunities for advancement

6. Ensuring equitable pay for peer support specialists

7. Ensuring the provision of training to the body of work and orientation to agency policies and procedures

8. Supportive supervision practices for peer support staff

9. Individualized support and reasonable accommodations for peer support staff

10. Providing opportunities for professional growth and development

11. Promoting ethical practice for peer support specialists

12. Promoting understanding of the role of mutual support in the provision of peer support

13. Promoting self-care for peer support staff

14. Fighting the stigma associated with mental illness

Requirements

Protocol 1 – Valuing the provision of peer support services in community mental health
Peers provide a living example of hope for others faced with the challenges of mental illnesses. The "if I can do it, you can do it" message doesn't even have to be spoken – it's right before their eyes. This often allows peers to engage and bond with people who otherwise would be reluctant to trust and use clinical services. They are advocates for recovery by virtue of the example they set as they work and share hope throughout their community. Peers can reach out and engage people otherwise unwilling to use behavioral health services. This is especially important because only 15 percent of people with serious mental illnesses are estimated to receive minimally adequate treatment (note: this is for the general population).

Hiring an individual who is in recovery and/or a parent or caregiver of a child or youth facing behavioral challenges to help others is empowering and provides an opportunity for them to utilize their unique knowledge and experiences as either a consumer of mental health services or a parent/caregiver of a child receiving mental health services. The work validates their prior experiences and can help them move toward a more fulfilling life.

Implementation guidelines:

1. Peer support specialist voices are respected and avenues are present at different levels of the agency to provide input and hope for recovery.

2. Peer support specialists are given meaningful assignments that really use their strengths and skills - not only driving, straightening the waiting room, or ordering/delivering lunches.

3. Formal peer support services delivered by peer support specialists are available in some format to all consumers utilizing the agency.

4. There are opportunities for input from peer support specialists relating to planning, development, and implementation of policy within the agency.

Protocol 2 – Integrating peer support specialists into the culture of each agency

Provider agencies and peer support specialists identified a need to recognize that hiring peer support specialists often leads to a cultural shift in traditional mental health settings. Provider agencies provide opportunities and support for that change to happen. The integration of peer support staff into a community mental health agency, while proven to be beneficial, can also be challenging for the peer and fellow agency staff. It is essential to recognize the degree to which the job of a peer support specialist includes the role of a change agent and to ensure that peer support specialists understand and explicitly choose this potential role and the manner in which they will carry it out.

Implementation Guidelines

1. Each network provider agency is encouraged to draft a plan to foster successful integration of peer support specialists into their agency. The peer support implementation plan would cover hiring practices and a plan for the integration of peer support specialists into the philosophy and working practices of the agency.

2. Training regarding the benefits of peer support is incorporated into the agency's orientation process for all staff. In addition, agency staff are encouraged to participate in training on peer support that MHCADSD and DBHR will make available to the provider network as needed and within available resources.

3. Peer support specialists are given opportunities to speak at staff meetings and trainings, as appropriate to the training / meeting content and as they are comfortable, and share their stories of success.

4. Peer support specialists working within an agency are allowed time to network, meet together, and debrief their roles in support of each other. If there is only one peer support specialist within an agency or organization, allowances are made for the peer support specialist to connect at least monthly with a fellow peer support specialist from a similar position for mutual support. This could be accomplished by attending a network of peer support specialist meeting provided by King County or other meetings facilitated by network providers.

5. Peer support specialists are helped to voluntarily understand their potential role as an agent of change and explicitly choose that role and the manner in which they will carry it out. To the extent that organizations expect peer support specialists to act as change agents, this is explicitly defined in the job description. In addition, staff are educated about this aspect of peer support services. As acting as a change agent is a challenging while fulfilling role, supervisory support for this role is imperative. The assigned supervisor understands the nature and challenges of acting as a change agent. If this aspect of the peer support specialist role is not expected, this is noted in the job description. Training in the role of the peer support specialist as an agent of change will be provided by MHCADSD and DBHR, as needed and within available resources, to ensure that this is understood across the provider network.

6. Provide training for all staff, including peer support specialists and their supervisors, to help them recognize that the experience of stigma can be victimizing and that combating stigma is the responsibility of all staff, rather than just the responsibility of the peer support specialist or other staff members with a history of mental illness.

Protocol 3 – Providing peer support within teams and promoting integration of peer support specialists as valued team members

Provider agencies and peer support specialists identified the need for peer support specialists to be a respected and responsible part of the treatment/recovery team. They must be integrated and included as valued team members.

Implementation Guidelines

1. There is a clearly defined team structure outlining specific roles and values to promote integration of peer support specialists with non-peer clinicians. The team structure:
    a. Describes the importance of consultation across disciplines for all team members.
        i. Peer support specialists to Mental Health Professionals (MHPs), physicians, and other non-peer clinical staff;
        ii. MHPs to physicians, peer support specialists, and other non-peer clinical staff;
        iii. Physicians to MHPs, peer support specialists, and other non-peer clinical staff; and
        iv. Other non-peer clinical staff to MHPs, peer support specialists, and physicians.
    b. Defines what is and is not part of each team member's role.
    c. Highlights the shared value across team members of helping people to recover.
    d. Supports routine communication between all team members.
    e. Clarifies that the peer support specialist represents the parent/consumer perspective to the team. When indicated, the peer support specialist also represents the guidance of the team to the parent/consumer.
    f. Describes the extent to which and how the peer support specialist carries out engagement, including limitations related to safety.
    g. If applicable, defines the peer support specialist role in assessment (for example, conducting a strengths summary), including any assessment activities that fall outside of the peer support specialist role.
2. The team supervisor role is critically important for creating and maintaining a team culture that understands and values the peer support specialist's role. The supervisor for the peer support specialist helps to create a team culture in which differences can be addressed in a productive and supportive manner
3. Specific team structure and roles are documented by the organization in a manner that either:
    a. Addresses all of the suggested areas in this Protocol or
    b. Notes why any suggested area is not addressed.
    c. The agency's organizational chart represents the presence of the peer support specialists in the organization.

4. When peer support is requested by an individual, the delivery of peer support is evident in the clinical record by review of the treatment plan, progress notes, and treatment reviews. Peer support specialists use standard documentation methods for recording consumer progress toward recovery goals.

5. King County and DBHR will provide training (as needed and within available resources) in the incorporation of peer support specialists into the treatment team.

Protocol 4 – Respecting shared experiences as the foundation of peer support

Provider agencies and peer support specialists identify a need to recognize that the role of a peer counselor is based on shared experiences, and it is essential that those experiences sufficiently match the population they are hired to serve. Peer support comes in many different formats. It can be provided as an individual service recipient for other individuals, parent/caregiver for parents/caregivers, youth for youth, or family member for family members. Each of these groups has unique experiences that must be respected and supported within the mental health system. However, it should be recognized that, while common experiences are needed, there will never be an exact match between the experiences of two different people.

Implementation Guidelines

1. Provider agencies recruit and hire peer support specialists who have similar experiences and background to the population they are being hired to serve through the use of clearly defined job descriptions and recruitment materials.

2. Provider agencies have policies that require a basis of common experience between peer support specialists and the people they serve.

3. King County will ensure that training and technical assistance are provided as needed and within available resources to support provider agency implementation.

Protocol 5 – Ensuring clear employment practices for peer counselors, including recruitment, job descriptions, orientation, and opportunities for advancement

Provider agencies and peer support specialists identify a need to have clear employment policies for peer support specialists. Peer support specialist positions have a specific purpose. The role of peer support specialist is an important and challenging position. It is essential that the person hired to fill this role be well qualified to provide support and ready to perform their specified job role in their community. A clearly defined and supportive job description allows the peer and those with whom they work to better understand the role they are being asked to play in the recovery process of others. Because peers are in their own process of recovery, and may be in transition from a dependence upon financial benefits and insurance provided by the state, many peers choose to work part-time. Provider agencies should support part-time work when necessary, appropriate, and possible.

Implementation Guidelines

1. Each agency has a clearly defined employment plan including non-discriminatory recruitment practices, a job description, hiring practices, and supporting policies in place to ensure the integrity of all agency roles including that of the peer support counselor. The plan should include:

    a. The process by which all peer employees will be recruited and hired;

b. A general plan for personal development and growth- promotional opportunities for the role of peer within the agency, including a variety of positions that take into account their own strengths and desires that may be other than strictly peer positions;

c. A clear outline of the chain of supervision for peer support specialists within the agency.

2. Job postings for Peer Support positions include a clear description of what is being sought. In general, a peer support specialist ought to:

a. Have relevant experience to the population being served by the program or agency;

b. Have an understanding of the basic principles of recovery as it relates to mental health;

c. Be at a point in their recovery where they are able to serve as a role model to others;

d. Be willing and able to share their personal story; and

e. Be able to articulate what has helped them in their recovery.

3. The hiring process takes into account the qualities that are needed for the peer support specialist position and candidates are screened accordingly. Peer support specialists are included on interview panels for new peer support specialist hires.

4. Provider agencies are flexible in setting work schedules, accommodating part-time peers whenever possible.

Protocol 6 – Ensuring equitable pay for peer support specialists

Provider agencies and peer support specialists observe that positions for peer support specialists are often viewed as entry-level positions and receive minimal pay, which sometimes does not fit the personal responsibility afforded to this position. Peer support specialists play an important role in the support of an individual's treatment and wellness. They are asked to share of their personal lives and are often put in difficult and challenging positions with the people they serve. This position needs to be compensated appropriately.

Implementation Guidelines

1. Peer support specialists are compensated based on data from a market analysis of like positions within their community. This analysis includes:

a. Consideration of special circumstances/job activities related to the role of peer support specialist;

b. The salary structure takes into account the value of life experience as well as formal education; and

c. The salary is commensurate with responsibilities and incorporated into the agency structure at an appropriate level.

2. King County and DBHR will provide available information to support agencies as available and as requested.

Protocol 7 – Ensuring the provision of peer support specialist training and orientation to agency policy and procedures

Provider agencies and peer support specialists identify a need for peer support specialists to be trained to the body of work. In addition, peer support specialists must be oriented to the agency and provided with training in the same manner as any other employee of the agency who provides direct services. The orientation should include information specific to the role of the peer support specialist within that agency. Personnel records reflect appropriate training, orientation, and ongoing training as for any other employee.

Implementation Guidelines

1. Peer support specialists may receive training that is part of a certified or non-certified curriculum. All peer support specialists must receive training in basic concepts of peer support as reflected in the manual used for the certification training, including:

    a. Active listening skills with the ability to pick up cues while listening and then respond appropriately

    b. Using personal experience to build empathy and rapport;

    c. How to be validating, provide information, and provide emotional support and encouragement

    d. Assisting in developing and implementing the service plan, including identifying life goals and the steps needed to achieve them.

    e. Assisting in reducing the sense of isolation and helplessness that consumers and families often feel;

    f. Assisting in building resiliency to the impact of stigma encountered by persons and families living with mental health challenges, including internalized stigma.

    g. Assisting in the development of self-advocacy skills.

    h. When to seek consultation and practicing within the scope of their training;

    i. Sharing their own recovery and resilience stories in ways that are relevant to the obstacles faced by consumers of mental health services;

    j. Recognizing and utilizing one's own unique strengths and experiences and apply them appropriately to the tasks at hand and to the relationships they have, both with colleagues and the consumers with whom they are working;

    k. Ethics, including

        i. Dual relationships and role conflicts;

        ii. Confidentiality and privacy;

        iii. Mandatory reporting;

        iv. Appropriate boundaries;

2. Peer support specialists shall receive continuing education as available internally or externally to the agency. The MHCADSD and DBHR will assist, as resources are available. Topics shall include:

    a. Training in illness self-management, such as the Wellness Recovery Action Plan process as developed by Mary Ellen Copeland or Illness Management and Recovery, among others; and for children, youth, and families, awareness of the principles of Wraparound, is strongly recommended.

    b. Understanding the prevalence and impact of trauma in the lives of service recipients and trauma's demonstrated link to overall health in later life, including the principles of trauma informed care;

    c. Principles of Motivational Enhancement;

    d. The unique aspects of working with someone who has co-occurring disorders, including substance use disorders, developmental disabilities, etc.

    e. Principles of whole health, including:

        i. Encouraging and supporting self-directed recovery;

        ii. Illness self-management and disease management;

        iii. Supporting choices to live tobacco-free, increasing physical activity, healthy diet choices, and social integration; and

        iv. Facilitating linkage and integration of primary health care and behavioral healthcare;

3. Orientation for the peer support specialist shall cover:

    a. General information about the agency and the programs they provide;

    b. The newly hired peer support counselor's chain of command;

    c. Safety practices for direct services staff, including self-care (managing stress, and burnout);

    d. Overview of job description;

    e. Overview of agency expectations regarding ethics and boundaries;

    f. Agency personnel and human resources (HR) policies (hiring, discipline, firing, grievance, leave procedures, accommodations).

    g. Training is provided to all staff, including peer support specialists, to promote understanding of differences between employee rights and consumer rights. For example, consumers are protected by laws guarding their right to confidentiality, but employees, including peer support specialists, are not. The training should encourage staff to be mindful of these differences. MHCADSD and/or DBHR will provide or support training in this area as requested and within available resources.

h. Training in dealing with secondary trauma is provided to all direct services staff, including peer support specialists. MHCADSD and/or DBHR will provide or support training in this area as requested and within available resources.

4. There is continuing education and training on at least an annual basis to ensure continued understanding of the topics covered in the orientation. In addition, the agency should identify at least one additional training issue to cover per year. Annual training shall include content addressing guidelines regarding mutual support (see Protocol 12.)

Protocol 8 – Supportive supervision practices for peer support staff

The professional success of peer support staff depends greatly on the quality and quantity of supervision they receive. The supervisor focuses on supporting the employee as they work to meet the expectations articulated in their job description within the context of agency values and the Practice Protocols.

Peer support specialists are to be held to the same level of accountability as other employees within the agency. To hold a peer counselor to a lower or higher standard of accountability is stigmatizing, is unfair to other employees, and denies the peer support specialist opportunities for professional growth. Peer support specialists are to be treated as employees, not mental health consumers or family members.

Implementation Guidelines

1. Supervisors treat peer support specialists as they would any other employee including:

   a. Avoid under or over-supervising peer support specialists;

   b. Respect and treat peer support specialists as valued employees;

   c. Keep the focus of supervision on the job;

   d. The supervisor recognizes that the peer support specialist may pursue therapeutic support for issues that fall outside of the supervisor/supervisee relationship and may recommend resources as appropriate. Example: referring a peer support specialist to the agency's Employee Assistance Program as would be the procedure for any staff employed by the agency; and

   e. Be familiar with these Protocols and the content of the Peer Counselor Certification Training used by DBHR and/or participate in training for peer supervision as available and offered by DBHR and/or King County to ensure understanding of the body of work by peer support specialists.

2. Peer support specialist supervisors exhibit the knowledge, skills, and attitudes necessary to supervise peer support specialists, including evidence that they:

   a. Are invested in the agency's decision to hire peer support specialists;

   b. Have an appreciation of the challenges faced by peer support specialists; and

   c. Have access to additional support and technical assistance due to the challenges associated with supervising this position.

3. Supervisors provide supervision only to individuals with whom they have never had a therapeutic or personal relationship.

4. Provide training for supervisors to help them be sensitive to the presence of stigma and proactive in supporting staff they supervise (including peer support specialists) to take steps to cope positively with its effects.

5. Supervision for all staff, including peer support specialists, is attuned to the need to support decision-making around appropriate and unethical mutual support. Supervisory meetings include discussions regarding boundary issues.

6. Supervisors of peer support specialists receive training on the Americans with Disabilities Act, Family Medical Leave Act, and Washington Family Leave Act and how to work with accommodations from request to implementation, in concert with agency human resources staff.

7. Supervision and any disciplinary actions taken are documented in accord with broader requirements for supervision, performance, and accommodation of disabilities.

Protocol 9 – Individualized support and reasonable accommodations for peer support staff

Peer support specialists qualify for their jobs to a significant degree because of a difficulty in their life rather than instead of it, so there may be the need for accommodations to support the person in the event of relapse or recurrence of these difficulties. It should never be assumed that because an employee is a peer support specialist that they will necessarily require extra support or accommodations. However, because peer support specialists by definition are either persons who have a history of mental health issues or are the parent of a child who has had a history of mental health issues, many peer support specialists may benefit from individualized support, as would any other staff person facing similar issues.

Examples of reasonable accommodations for people with severe mental illnesses included providing self-paced workloads and flexible hours, modifying job responsibilities, allowing leave (paid or unpaid) during periods of hospitalization or incapacity, assigning a supportive and understanding supervisor, modifying work hours to allow people to attend appointments with their psychiatrist, providing easy access to supervision and supports in the workplace, and providing frequent guidance and feedback about job performance.

An employer is not required to provide an accommodation if it will impose an "undue hardship" on the operation of its business such as accommodations that are excessively costly, extensive, substantial, or disruptive, or would fundamentally alter the nature or operation of the business.

Implementation Guidelines

1. All requests for accommodation are documented in accord with broader agency policy and procedures related to disabilities. The requests are handled professionally and expeditiously.

2. If a peer support specialist has a reasonable accommodation in place related to a disclosed disability, it is appropriate to use a different standard if that is part of the accommodation. However, the agency has a right to require adequate performance of documented job duties.

Protocol 10 – Providing opportunities for professional growth and development

Peer support is a valuable resource in a recovery based system and peer support specialists need opportunities to gain knowledge and advance within the profession. Some peer support specialists may choose to advance as peer counselors, including the potential of developing supervisory skills. Other peer support specialists may choose to pursue other jobs within the agency for which they qualify, including other clinical, mental health professional, and administrative jobs.

Implementation Guidelines

1. As with any staff member, the agency provides clearly defined policies and procedures regarding opportunities for training and advancement for peer support specialists which may include:

    a. Expanded responsibilities as a peer support specialist;

    b. Potential advancement into supervisory roles over other peers/agency staff; and

    c. Opportunities to pursue other clinical and administrative positions for which they qualify.

2. Peer support staff are encouraged to work with their supervisor to create a personal training, growth and development plan.

Protocol 11 – Promoting ethical practice for peer support specialists

Peer support specialists are held to the same ethical standards as other members of agency staff. All staff, including peer support specialists, who work in King County provider agencies are held to high ethical standards in their work with consumers and families. Agencies that choose to hire peer support specialists who also receive services from the agency shall ensure ethics regarding dual role issues are strictly adhered to. Ethical standards for the work provided by peer support specialists, parent partners, and youth peer specialists is in development nationally.

Implementation Guidelines

1. Agencies employing peer support specialists ensure that their staff receive the state approved peer counselor certification training or the equivalent (see Protocol 7). This training may be provided on-the-job with close supervision and support from other trained peers during an initial probationary period during which a peer support specialist is awaiting a training opportunity (due to an often long wait list to get into the state approved training).

2. Peer support specialists are provided with the same training as other clinical staff within their agency regarding the agency's ethical guidelines. Training is provided at orientation and ongoing, in accord with agency policy and state requirements.

3. The agency has a plan and policies and procedures in place to protect the confidentiality and rights of any employee who also receives services there.

4. Clinical records of employees who are receiving services within the agency re only accessible to their direct service providers, to the extent feasible.

    a. The employee is made aware of any limitations in this confidentiality protection of their clinical records.

b. A method for inquiry and issue resolution is identified and communicated to any employees who are also clients. This process offers recourse for any employee who believes their dual role as a client has been compromised.

5. Agency staff, including supervisors and peer support specialists, shall be provided information about emerging core ethical standards, including the code of ethics for parent partners articulated in the Individualized & Tailored Care/Wraparound Parent Partner Manual and those developed by the organization InterNational Association of Peer Supporters, released nationally in 2013 (see References).

Protocol 12 – Promoting understanding of the role of mutual support in the provision of peer support

The boundaries involved in the provision of peer supports are different than those involved in the provision of other clinical services. These boundaries need to be clearly defined to provide protection for the peer and for the people they are asked to serve. All team members need to understand the boundary between appropriate mutual support and inappropriate seeking of support or providing "counseling" to each other.

Implementation Guidelines

1. The provider agency has policies and procedures that address appropriate boundaries for all staff and provides regular training for staff to define and promote a positive understanding of mutual support that includes the following definitions and boundaries. MHCADSD and/or DBHR will provide or support training in this area as requested and within available resources. Key components of the policies, procedures and training should include:

   a. A definition of mutual support (two people helping each other) as a positive occurrence and one of the principles underlying the positive impact of peer support;

   b. Recognition that mutual support can occur freely if there is no power differential between the two people helping each other;

   c. When a person is in the role of providing services or being a mentor, that peer should limit their sharing to positive, proactive elements and avoid unburdening themselves of unmet challenges, which may be overwhelming them. It is important to give the people receiving support the opportunity to be empowered through the experience of giving back support to the peer specialist. This is one of the essential aspects of mutual support. However, the peer specialist or facilitator should not be unburdening themselves of problems which are beyond what can reasonably be expected to be handled by the people who are supposed to be the ones receiving the services or support. When the exchange of support becomes overburdened by the demands of the peer specialist or facilitator, an unacceptable burden is placed on those who come to the experience seeking help for themselves.

   d. Acknowledgement that power differentials can lead to situations in which limits must be put on the receipt of mutual support by the person in the more powerful position; these include:

      i. If a person is in a formal role to provide help, there is a duty to provide help on the part of the person in the formal role. This is true whether or not the peer support specialist is in a paid or volunteer position (including internships.)

2. There is consultation available in the organization to help any staff member determine when the receipt of support by the helper becomes unethical.

Protocol 13 – Promoting self-care for peer support staff

Like other direct service roles in community mental health settings, the role of a peer support specialist is a stressful position and the person filling the role must be cognizant of personal limitations and practice good self-care in the same manner as would any other staff member providing direct services in an agency. Peer support specialists also face stresses unique to their role. Provider agencies and peer support specialists must recognize the challenges faced in their role and be supported and encouraged in practicing good self-care so that they may be successful in their position. In addition, supervisors and co-workers need to respect the difficulties peer support specialists face and be supportive of their self-care activities.

Implementation Guidelines

1. All staff, including peer support specialists, are encouraged to use good self-care as a way to manage stress in their work.

2. Peer support specialists and all clinical staff are given opportunities to debrief difficult job-related situations with supervisors as part of regularly scheduled supervision.

3. Peer support specialists are supported when they need to utilize sick leave and vacation to take care of personal or family needs per agency policies.

4. All staff are encouraged to participate in training and other activities that provide support for self-care within their roles in the agency.

Protocol 14 – Fighting the stigma associated with mental illness

Provider agencies and peer support specialists observe the need to actively combat the effects of the stigma of mental illness within the employment setting on an ongoing basis.

Implementation Guidelines

1. The provider agency has policies, procedures, and regular training for staff regarding the reduction of the stigma of mental illness and the promotion of social inclusion.

2. The policies, procedures, and training also promote diversity.

3. The provider agency has policies and procedures that define how any staff member (including peer support specialists) that experiences stigma can positively address the stigmatizing experience.

4. Provide opportunities for peer support specialists to receive regular mutual support and peer consultation from other peer support specialists that includes mutual support to cope with the effects of stigma.

5. Agency policies, procedures, and practices promote the use of person-first language and discourage references to people by labels such as diagnoses.

Arizona Department of Health Services, Division of Behavioral Health Services. (2007). ADHS/DBHS Clinical and Recovery Practice Protocol: Peer Workers/Recovery Support Specialists within Behavioral Health Agencies.

Carlson, L. and McDiarmid, D. (1999). Consumers as Providers of Mental Health Services, A Literature View & Summary of Strategies to Address Barriers. University of Kansas School of Social Welfare.

Clark County Peer Support Guidelines (2009). Clark Regional Support Network, Washington State.

Daniels, A., Grant, E., Filson, B., Powell, I., Fricks, L., Goodale, L. (Ed). (2010). Pillars of Peer Support: Transforming Mental Health Systems of Care Through Peer Support Services, www.pillarsofpeersupport.org; January, 2010.

Gates, Lauren B. and Akabas, Sheila H. (2007). Developing Strategies to Integrate Peer Providers into the Staff of Mental Health Agencies. Administration and Policy in Mental Health, 34(3), 293-306.

InterNational Association of Peer Supporters (2013). National Practice Guidelines for Peer Supporter.

King County Regional Support Network. (2007). Peer Support Services Benefits and Guidelines.

King County Regional Support Network. (2009). Standards for Peer Support Services.

Larsen, N. (2005). Recovery Services Development Resource Handbook. Chicago, IL: Recovery Services Development Illinois Division of Mental Health.

Miles, Patricia, (2001). The Individualized & Tailored Care/Wraparound Parent Partner Manual. Portland, OR., page 4.; 503 618 1088. July, 2001.

O'Brien, J., Tiegreen, W. and Campbell, J. (July 2008). Independent Living Research Utilization in Collaboration with Human Services Council Research Institute. Policy Issue #2: Introducing and Supporting Peer Providers in Traditional Mental Health Provider Networks, Houston, TX: ILRU Program.

Extraordinary Occurrence Report - Confidential
King County Mental Health, Chemical Abuse and Dependency Services

Provider Agency | Client's Name (if CD)

Client's Date of Birth | Age | KCID #

Gender | Ethnicity

Client Receiving (check all that apply)

- ☐ Mental Health Services
- ☐ Chemical Dependency Services
- ☐ Both MH and CD Services
- ☐ King County Crisis and Commitment (CCS)
- ☐ MH Services from another provider
- ☐ CD Services from another provider

Type of Incident (click on right-side arrow to see options)

Date of Incident | Time of Incident

Description of Incident (including what took place and, if known, the location of the incident; names, ages, service histories, and nature of involvement of all individuals involved in the incident; and whether eloped client was classified as a mentally ill offender or sexually violent offender):

Provider Response to Incident (including steps taken to minimize harm and, if applicable, whether reported to law enforcement, restraining/protection order sought, workplace safety/personal protection plan developed or implemented; summary of debriefings):

Date Provider Learned of Incident | Date of Last Face-to-Face Visit

Client's Current Location (click on right-side arrow)

If Client's location is unknown, describe attempts to locate:

Client's Current Condition/Status:

Programs (please check all that apply):

- ☐ Crisis and Commitment Services (CCS)
- ☐ Evaluation and Treatment (E&T)
- ☐ Next-Day Appointments (NDA)
- ☐ Geriatric Regional Assessment Team (GRAT)
- ☐ Children's Crisis Outreach Response System (CCORS)
- ☐ Outpatient Mental Health
- ☐ Mobile Crisis Team
- ☐ Residential Housing (e.g., Supervised Living, Long-Term Rehabilitation, Standard Supportive Housing)
- ☐ Detox
- ☐ Opiate Substitution Therapy
- ☐ Criminal Justice Initiatives
- ☐ Outpatient Chemical Dependency
- ☐ Residential Chemical Dependency
- ☐ Program for Assertive Community Treatment (PACT)
- ☐ Crisis Respite Program
- ☐ Crisis Solutions Center / Crisis Diversion Facility

Other Program

Incident Reported to (please check all that apply):

☐ Child Protective Services ☐ Law Enforcement ☐ Adult Protective Services ☐ Other Regulating Body

Date of Last Medication Management Session (if applicable)

Person Completing Form (Name/Title)

Supervisor's Name/Title, verifying that standard review procedures for this extraordinary occurrence are being followed and that the provider agency will complete the standard review process within 30 days of the occurrence.

Phone Email

This form can be saved, printed, and faxed to King County MHCADSD at 206-296-0583. You can also send it (using secure email) as an email attachment. If you are sending it via email, please send it to Mary.Paterson@kingcounty.gov and cc Cristina.Bravoderueda@kingcounty.gov, Max.Lewis@kingcounty.gov, and Sean.Davis@kingcounty.gov .

EXTRAORDINARY OCCURRENCE 30-DAY STANDARD REVIEW
CONFIDENTIAL
KING COUNTY
MENTAL HEALTH PLAN

Provider agency:_____ ☐ Initial review report ☐ Revised review report

Date of Incident: _____ KCID _____

Has there been or will there be a medical examiner's investigation of this death? ☐ Yes ☐ No

Does this report incorporate the medical examiner's findings? ☐ Yes ☐ No

Description of event:_____

_____

_____

_____

_____

_____

_____

Staff names, titles, and dates of all that participated in review of this incident:_____

_____

_____

_____

_____

Action resulting from review activities (see Section X, Quality Management). Any treatment plan changes need not be described in detail:

_____

_____

_____

_____

Supervisor:_____ Date: _____

Practice Protocols for Recovery and Resiliency-oriented Mental Health Services

Purpose:
King County Ordinance #17553, passed in 2013, requires implementation of the King County Recovery and Resiliency Oriented Behavioral Health Services Plan 2012 – 2017. Protocols for Recovery and Resiliency Oriented Behavioral Health Services are included in the Plan to be implemented as one of a set of strategies to shift to a model grounded in recovery. People who live with mental health challenges identified the fundamental components of recovery to include:

- Self-Direction
- Individualized & Person-Centered
- Empowerment
- Holistic
- Non-Linear
- Strengths-based
- Peer Support
- Respect
- Responsibility
- Hope
- Resiliency

Existing policies and procedures specify what needs to happen when for people participating in mental health services. The Practice Protocols address the way services are provided to better express the fundamental components of recovery. The Protocols reflect the dictum articulated by the community of people living with disabilities, "nothing about us without us" as they have been developed in partnership with providers and clients.

Expected System Outcomes:
The expected outcome is a system that continues to evolve to meet the promise of recovery. The recovery initiatives to date have created a strong foundation from which to build these protocols. The protocols address recovery and resiliency as supportive of overall health and wellness. The ultimate goal is better outcomes for the people receiving services.

While the protocols may become a guideline for practice liable to be reviewed for compliance, they are intended to be a blueprint for system change, and are understood as ideals representing a developmental process that will take a number of years to fully implement.

Definitions:
Client: means a youth, adult, or older adult; OR the family and/or caregiver of a child who receives mental health services in the publicly funded mental health system in King County. People who live with mental health challenges have the right to self-define in terms of how they are addressed, understanding that they are people first.

Trauma-informed care: The protocols begin with an attitude of respect; emphasize the sharing of information; support connection to self, family, and community; and perhaps most importantly, offer hope for recovery and resiliency. Choices are offered whenever possible and appropriate. This is important for recovery and resiliency as people living with mental illness have a high incidence of trauma.

Protocols: Practices that demonstrate the fundamental components of recovery-oriented services. These practices can be adapted to fit the unique needs of each agency or program.

Examples are offered as suggestions and should be adapted to fit the unique needs of each agency or program. The examples can be a demonstration that the Protocol has been achieved, as in "You'll know you've achieved this Protocol when…" If an agency meets the Protocols in ways other than those suggested by the examples, the methods must be articulated in agency policy and procedures.

Other definitions and principles of recovery and resiliency-oriented mental health services are described elsewhere in the King County Regional Support Network Mental Health Plan Policies and Procedures.

Protocols:

1.0 Governance

1.1 The governing board of each mental health provider agency shall be briefed at least quarterly by agency management regarding agency progress relative to the King County recovery and resiliency initiatives.

1.2 The governing board shall include a role for at least one person who self-identifies as a person with lived experience of mental health recovery.

1.2.1 If the mental health services are part of a much larger organization where the governing board is elected and/or has responsibility over many unrelated programs, the mental health program may substitute a local advisory committee that includes at least one person who self-identifies as a person with lived experience of mental health recovery.

1.2.2 Clients who become members of boards shall receive appropriate orientation to board function and how to be an active member.

2.0 Culture

2.1 Agencies shall provide waiting rooms, reception areas, and other areas clients gather that are welcoming and communicate a sense of safety, respect, and hope. Those serving children, youth, and families shall likewise provide an appropriate environment for their needs.

Examples include:

- Reception staff that are accessible, friendly, and welcoming;
- Colorful and interesting art;
- Magazines and other reading material that is in good repair, relatively current, and reflect the cultures and ages of the persons served;
- Plants, aquariums, toys, crayons, etc.;
- Facility, furniture and carpets in good repair;
- Lighting that is sufficient to read;
- Posters and literature about recovery and resiliency; and
- Staff help create a space that is physically and emotionally safe for those using the space.

2.2 Common areas are to be inclusive for those that use them. In as much as possible, agencies avoid giving the impression of "us versus them."

Examples include:

- Reception staff easily accessible (rather than behind bullet proof glass with small windows); and
- Bathrooms for inclusive for everyone (rather than staff bathrooms separate from clients).

2.3 All staff engages with the person rather than with the diagnosis or disability, building trust over time.

2.4 Throughout care, efforts are made to record client responses in their own words and in context rather than translating the information into professional language.

2.5 Agencies offer evidence-based practices as much as possible and when practical to do so.

2.6 To integrate employment within the larger system, the task of encouraging people to consider and engage in employment and/or education is the responsibility of the entire network, including those not specifically charged with supported employment or education tasks.

2.7 Recovery and resiliency principles and practices are considered for each special population served by the agency (e.g. youth, gender, older adults, diverse cultures, etc.)

2.8 Recovery and resiliency principles and practices are incorporated throughout all agency-written materials, including policies and procedures, clinical forms, records, brochures, client handbooks, websites, or other media.

2.9 Respect is demonstrated by simple courtesy (as age appropriate.)

Examples include:

- Phone calls returned in a timely manner;
- Personal boundaries and personal space are respected;
- Everyone is treated in an age-appropriate manner;
- Privacy is protected; and
- Appointments begin and end on time, as much as possible.

2.10 Relapses in substance use and exacerbations of psychiatric symptoms are to be viewed as evidence of the challenges of the person's condition and the non-linear nature of recovery; rather than indicative of a poor prognosis, non-compliance, or the person is not trying hard enough to recover.

2.11 Agency policies shall support hiring persons who have mental health challenges for a variety of positions, not only peer support specialists.

2.12 All staff work as partners with clients, collaborating to assist the person to reach their goals.

2.13 Services are grounded in an appreciation of the probability of improvement in the person's life, offering people faith and hope that recovery is "possible for me."

2.14 The focus of services is on recognizing, enhancing, and using existing strengths and resiliency, sometimes called "building recovery capital."

3.0 Clients

3.1 Clients, including families, shall be offered information about recovery and resiliency at intervals appropriate to the client's needs and interests. King County shall provide technical assistance and resources when available.

Examples include:

- Literature provided at the time of intake;
- Posters and literature available in the waiting rooms/reception area and other places clients congregate, including virtual space, e.g., on an intranet available to clients;
- Psycho-educational groups;
- One-on-one by a mental health worker, who may be a peer support specialist;
- Celebratory and educational events provided for clients to provide information and resources about mental health recovery and resiliency; and
- Other methods as identified by the agency.

3.2 Each person served is provided with an orientation to agency practices, how best to utilize services and what to expect as well as what will be expected. This can be provided in a variety of ways.

Examples include:

- Via the intake process;
- A mental health worker who may be a peer support specialist;
- Written and electronic materials; and
- Other methods as identified by the agency.

3.3 The agency shall establish and support an ongoing consumer advisory group(s):

3.3.1 The group(s) may be called a committee, a panel, a bureau, etc.

3.3.2 The agency shall provide a group charter or group description.

A. The charter or description shall outline the expectations and responsibilities of the group, including:

1. Review of the agency's planning, implementation, and evaluation of recovery and resiliency-oriented initiatives, both those required by King County and those generated by the agency itself.

2. Methods whereby the group provides input, assists in identifying barriers, recommends strategies to address those barriers, and receives feedback regarding those recommendations.

3. A process for resolution of conflicts among members when indicated, with the participation of agency staff.

B. Once the committee is formed, the committee shall review the description/charter and provide feedback and recommendations for changes.

C. The agency shall have final authority and responsibility for the content of the charter or description.

3.3.3 The agency shall provide a staff liaison that may or may not be a co-facilitator of the group.

3.3.4 This group must have a formal relationship with the agency's quality management process. This shall include:

A. A way for the group to provide recommendations for improvement;

B. A way for the group to be updated about the agency's plan and progress to a recovery and resiliency orientation; and

C. A way for the group to receive feedback about recommendations to the agency.

Examples include:

- A staff liaison who also sits on the agency's quality management team;
- A member of the group who also sits on the agency's quality management team; and/or
- Written reports from one group to another.

D. The majority of the members of the group shall be clients of the agency who are not also employed by the agency.

E. The group must be of a size and composition commensurate with the size and complexity of the mental health services of the agency.

F. The agency's executive leadership shall participate in meetings of the group periodically.

G. The group members shall be provided with an orientation, including:

1. How the group functions (Robert's Rules of Order, steps involved in conflict resolution, etc.);

2. Roles in the group (chair, vice chair, etc.);

3. The publicly funded mental health system in King County;

4. The Practice Protocols for Recovery and Resiliency-oriented Mental Health Services;

5. The agency's structure, funding, and organizational hierarchy; and

6. The agency's plan and progress on recovery and resiliency initiatives.

3.3.5 Stipends

A. Stipends are encouraged where possible.

B. If stipends are provided, clients shall be informed that stipends must be reported as income.

C. Clients shall be offered appropriate benefits counseling if receiving stipends.

3.3.6 The committee shall be informed that they are invited to send a member to attend quarterly meetings of the Voices of Recovery, a consumer advisory committee for King County.

3.4 The agency's executive director, chief executive officer, or their designee shall meet at least quarterly with clients to listen and respond to their concerns and perspectives. (Meeting quarterly with the agency's client advisory group would meet this standard.)

3.5 Information and agency updates are available routinely to people in recovery and their loved ones.

Examples include:
- A newsletter;
- Website;
- Postings in the reception area;
- Information shared in ongoing consumer groups, etc.

4.0 Staff Reference: Foundational Mental Health Recovery Competencies and Curricula – Appendix A.

4.1 Job announcements and recruitment and hiring processes (job interviews) shall include a review of an applicant's mental health recovery competencies according to the Foundational Mental Health Recovery Competencies and Curricula.

4.2 Performance evaluations shall include the following considerations where possible:

4.2.1 Assessment of Foundational Mental Health Recovery Competencies.

4.2.2 Assignment of Foundational Mental Health Recovery Curricula for any competencies not already met.

4.2.3 Review of recovery outcomes of the clients on a staff person's caseload, e.g. housing, employment, etc.

4.3 Clinical staff recognition, promotion, and financial incentives (when available) shall take into account recovery and resiliency-oriented skills and outcomes.

4.4 Clinical staff shall participate in training to build skills and practices in accord with the King County Mental Health Recovery and Resiliency Oriented Clinical Skills Inventory (Appendix B). Clinical staff includes:

4.4.1 Psychiatric practitioners; and

4.4.2 All other clinical staff that has direct contact with clients, including peer support specialists.

4.5 Organizations are encouraged to provide recovery and resiliency training for non-clinical staff that have direct contact with clients. King County MHCADSD will provide training as resources permit.

4.6 Persons with lived experience of recovery shall participate in training staff about recovery and resiliency. This may include clients and/or peer support specialists. Stipends to recognize this contribution and the expenses people may incur for this participation are encouraged.

4.7 Staff are given multiple opportunities to hear recovery stories from the people they have worked with, and known in times of severe illness.

4.8 Staff members from all levels of the organization are informed about the agency's planning, implementation, and evaluation of efforts to provide services from a recovery and resiliency orientation, including initiatives required by MHCADSD (e.g. performance toward incentive targets).

4.9 In as much as possible, program designs prioritize therapeutic relationships. Research has repeatedly shown that a therapeutic relationship perceived by the client as safe and positive is critical to good outcomes.

4.10 Staff encourage people to claim their rights and to make meaningful contributions to their own care and to the system as a whole.

4.11 Language

4.11.1 Staff are mindful of the power of language and carefully avoid the subtle messages that professional language has historically conveyed to persons living with mental illness, addictions, and their loved ones.

Examples include:

- Referring to someone who lives with depression as "suffering from depression," as "suffering" is a self-description concept to be used only by the person who is experiencing the "suffering";
- "Case management" as people are not cases to be managed; and
- "Compliance" which suggests mindless conformity and the need to be taken care of as like a child. Terms like involvement, adherence, partnership, and cooperation are less passive, and more suggestive of someone taking responsibility for his or her own recovery.

4.11.2 Staff educate people about their diagnosis while avoiding the use of diagnosis as a short cut to refer to a person or as a label because labels yield minimal information regarding the person's experience or manifestation of illness or addiction. Two people who both have the diagnosis of schizophrenia are more different than they are alike.

4.11.3 Language used by staff is neither stigmatizing nor objectifying. "Person first" language is used to acknowledge that the person's individuality and humanity is more important than their illness.

4.11.4 Exceptions to person-first and empowering language that are preferred by some persons in recovery are respected.

5.0 Access to Care

5.1 The agency shall promote access to care by facilitating swift and uncomplicated entry; and by removing barriers to receiving care, as much as possible, given access to care rules.

5.2 People can access a wide range of services from many different points.

6.0 Assessment

6.1 Assessment begins at intake and is revisited during recovery planning, and periodically throughout services.

6.2 Assessment includes listening and clarifying with the person their life story, not simply a recording of reported symptoms and problems. Simple, yet powerful, questions can be helpful, such as "What happened? What do you think would be helpful? What are your goals in life?"

6.3 The message that recovery is not only possible but probable is communicated explicitly via statements and questions.

Examples include:

- "This is your recovery, how can we be helpful?"
- "I believe your life can get better;"
- "Working together, we will get your life back on track;"
- "What would your best life look like?"

6.4 Staff realize and communicate that all parties bring a certain expertise to the table, understanding that individuals (and parents and caregivers of children,) have learned much in the process of living with and working through their struggles.

6.5 Staff include the subjective experience of the person. This includes what motivates them, their hopes and dreams, what they are concerned about. Staff endeavor to see their situation from their perspective.

6.6 Agencies balance the requirement to establish medical necessity with an approach that is solution-focused and supportive of recovery. Medical necessity requires identifying what isn't working in a person's life. Much of the information required for medical necessity will emerge from the person's life story and the reasons they have come in for services.

For example:

- The person's stated goals are frequently the positive outcome of changes to what isn't working. If the client's goal is to get a job, when discussed, the client reveal difficulty in social situations, disorganized thought processes, etc.; and
- When a client describes symptoms that interfere with life goals, a hopeful and strengths-based response can acknowledge that symptoms are often disguised strengths. The ability to dissociate can be powerfully protective when a person is in a

traumatic situation. Thus, recording symptoms to establish medical necessity can include reframing the symptoms in ways that acknowledge strengths.

6.7 A discussion of strengths is a central focus of every assessment. A discussion of challenges, problems, and issues within a strengths and resilience-based framework allows the individual to identify less with their illness. Exploring areas not traditionally considered "strengths," can be helpful.

Examples include:

- The individual's most significant or most valued accomplishments;
- Preferred ways of relaxing and having fun;
- Adaptive techniques the person has developed;
- Personal heroes; and
- Educational and social achievements, etc.

6.8 While strengths of the individual are a focus of the assessment, thoughtful consideration also is given to potential strengths and resources within the individual's family, natural support network, service system, and community at large.

6.9 Assessments explore the whole of people's lives while ensuring emphasis is given to the individual's expressed and pressing priorities. This includes life roles such as parent, spouse, partner, worker, etc.

6.10 Cause-and-effect explanations are offered with caution; as such thinking can lead to simplistic resolutions that fail to address the person's situation. In addition, simplistic solutions may be perceived as assigning blame for the problem to the individual.

6.11 Assessment shall be trauma-informed in that the focus is on what happened to the person, rather than a sole focus on what is wrong in the person's life. Many individuals with behavioral health disorders also have histories of trauma. Attending to such histories may support the person's recovery and resiliency.

7.0 Recovery Planning for the Individual Service Plan (ISP)

7.1 Development of individualized person centered plans shall occur in a process of shared decision making – See this link (as of 2014) http://store.samhsa.gov/shin/content//SMA09-4371/SMA09-4371.pdf

7.2 Opportunities for employment, education, recreation, social and civic involvement, and religious participation are identified by the person in recovery via any useful or effective means such as community resource guides like *2-1-1 and the Where to Turn guidebook.

7.3 The focus of care shifts from preventing relapse to promoting recovery and resiliency.

7.4 Goals and objectives are defined by the person with support from staff, with a focus on pursuing a life in the community; rather than defined by staff-based on clinically-valued outcomes (e.g., reducing symptoms, increasing adherence).The focus of planning is about building a meaningful and successful life in the community, including employment and/or other meaningful life activities, not merely maintaining clinical stability or abstinence.

7.5 People are asked what has worked for them in the past and when useful, these strategies may be incorporated in the individual service plan (ISP).

7.6 Plans respect the fact that services and practitioners may not remain central to a person's life over time. As appropriate, strategies to transition to independence from the behavioral health system are clearly defined.

7.7 The ISP shall reflect the range of formal and informal supports a person might utilize for their recovery, not only those provided by the agency.

Examples include:

- Peers in paid or volunteer positions;
- Mutual aid groups;
- Indigenous healers;
- Faith community leaders;
- Schools;
- Community and social groups and clubs;
- Primary care providers; and
- Other natural supports.

7.8 Individuals are seen as capable of illness self-management. Interventions support this as a valued goal of recovery-oriented services. Illness self-management strategies and daily wellness approaches, such as Wellness Recovery Action Plan TM, are respected as highly effective, person-directed recovery tools, and are fully explored and utilized.

7.9 Within the planning process, a diverse, flexible range of options are available so that people can access and choose those supports that will best assist them in their recovery.

7.10 Plans consider not only how the individual can access and receive needed supports from the behavioral health system and the community, but how the individual can connect with others for mutual support.

7.11 Movement through a pre-set sequence of care is not required, as recovery is neither a linear process nor a static end product or result.

8.0 Ongoing Services

8.1 An individual's stage of change is considered at all points in time. Providers endeavor to meet each person where he or she is in the change process. Motivational assessment is continual and interventions are designed to enhance wellness and recovery.

8.2 Individuals are allowed the right to make mistakes, and this is valued as an opportunity for them to learn.

8.2.1 Unless determined by a court to require guardianship, individuals are presumed competent and entitled to make their own decisions.

8.2.2 Staff offer their expertise and suggestions respectfully while working with the person to identify the range of options and their possible consequences, both positive and negative.

8.2.3 Staff continue to try different ways of engaging and persuading individuals that respect the person's ability to make choices on their own behalf.

Examples include:

- Phone calls;
- Letters;
- Visits to locales the person is known to visit;
- Contacting other professionals involved with the person; or
- Contacting informal supports for whom staff has a release of information.

8.2.4 Even in the earliest stages of recovery, staff assume the person's substance use disorder and/or psychiatric disorder is less a defining characteristic and more simply one part of a multi-dimensional sense of identity.

8.3 Interventions are aimed at helping people to gain autonomy, power, and connections with others.

8.4 Opportunities and supports are provided for the person to enhance his or her own sense of personal and social efficacy.

8.5 People are allowed to express their feelings, including anger and dissatisfaction, without having these reactions automatically attributed to an illness.

8.6 Care is attentive to cultural differences across ethnicity, and other distinctions of difference (e.g., age, sexual orientation, gender, gender history, socio-economic status, religious affiliation/belief, language, national origin, immigration status/history, developmental and intellectual ability, mobility, and/or sensory impairments).

8.7 Staff focus on preparing people for the next steps of the recovery process by anticipating what lies immediately ahead, by focusing on the challenges of the present situation, and by identifying and helping the person address anticipated potential obstacles versus; dwelling on the past or worrying about the future.

8.8 When people express reluctance, fear, mistrust, and even disinterest in assuming the right and support to take control of their treatment and life decisions, staff assist them to explore and address the many factors influencing such responses. This is an important component of assessment and ongoing care and is basic to the recovery process.

8.9 When a client appears to disengage, the central concern shifts from: "How do we get the client into treatment?" to: "How do we support the process of recovery within the person's natural environment?"

8.10 Staff look for signs of systemic, social, and/or organizational barriers or other obstacles to care before concluding that a client is non-compliant or unmotivated.

8.11 Agencies do not exclude clients from ongoing care based on symptomatology, substance use, or unwillingness to participate in prerequisite clinical or program activities.

9.0 Crisis Services

9.1 Staff encourage individuals to devise and consult their own crisis plan, advance directives, and other documents designed to assist in illness management, assisting them to update the documents when indicated, including identification of natural supports, nontraditional sources of support, and creative (in addition to traditional medical model) interventions.

9.2 Staff take a holistic approach to assessing a crisis, considering that adults, children, families, and older adults with a serious mental illness or emotional disorder often lead lives characterized by recurrent, significant stressors. Crises often represent the combined impact of multiple factors rather than the illness, per se. These factors may include lack of access to essential services and supports, poverty, unstable housing or homelessness, coexisting substance use, other health problems, discrimination, institutionalization, and victimization.

9.3 Staff understand that a crisis often severely impacts a person's normal abilities and responses, particularly a person with a history of trauma. Choices are offered in as much as possible.

9.4 Staff anticipate that a crisis event may become a cascading crisis that may be traumatic in and of itself. Admission to a psychiatric institution may feature forcible removal from one's home; being taken into police custody, handcuffed and transported in the back of a police car; evaluation in the emergency department of a general hospital; transfer to a psychiatric hospital; a civil commitment hearing; and so on. At multiple points in this series of interventions, there is the possibility that physical restraints, seclusion, involuntary medication or other coercion may be used.

Intense feelings of disempowerment are definitional of mental health crises, yet as the individual becomes the subject of an intervention, the person may experience diminishing sense of control. In addition, when a client is detained in jail or the hospital or is voluntarily hospitalized, additional crisis can result such as rent having not been paid, the client's pet not having been attended to, etc. Natural supports may be a resource in attending to ancillary concerns such as a pet being fed, rent covered, etc.

9.5 Staff endeavor to respond to crises according to the following values and principles of crisis services identified and defined by SAMHSA in the document, "Practice Guidelines: Core Elements in Responding to Mental Health Crises". (See: http://store.samhsa.gov/shin/content//SMA09-4427/SMA09-4427.pdf for more information.)

9.6 Coercive measures are used only as a last resort, after all less restrictive measures are employed.

9.7 Staff endeavor to consider the following ten essential values when responding to crises:

- Reducing or minimizing risks of additional harm and ensuring a sense of emotional and physical safety.
- Intervening in person-centered ways.
- Sharing responsibility, including responsibility for managing risk in accordance with the capacity of the client.
- Providing trauma-informed care.
- Establishing feelings of personal safety.

- Basing interventions on strengths.
- Addressing the whole person.
- Addressing the person as a credible source.
- Preserving dignity, supporting ongoing recovery, resiliency, and natural supports.
- Prevention of future crises.

9.8 The following principles are to be employed when enacting the ten essential values for crisis services (in as much as possible):

- Access to supports and services is timely.
- Services are provided in the least restrictive manner.
- Peer support is available.
- Adequate time is spent with the individual in crisis.
- Plans are strengths-based.
- Emergency interventions are considered in the context of the individual's overall plan of services, advance directives (if available,) and any other plan for crisis management.
- Crisis services are provided by individuals with appropriate training and demonstrable competence to evaluate and effectively intervene.
- Individuals with a self-defined crisis are not turned away.
- Interveners have a comprehensive understanding of crisis.
- Helping individuals regain a sense of personal control is a priority.
- Services are congruent with the culture, gender, race, age, sexual orientation, and communication needs of the individual being served.
- Rights are respected.
- Services are trauma-informed.
- Recurring crises signal a possible mismatch between care and needs. A review of the assessment and the individual services plan may be useful.
- Meaningful measures are taken to reduce the likelihood of future emergencies.

Foundational Mental Health Recovery Competencies and Curricula

All members of the mental health workforce who work with people whose services are publicly funded via the King County Mental Health Plan shall receive training in recovery and resiliency principles. The foundational competencies are described in Section I. The courses and curricula that will address the competencies are described in Section II. All newly hired staff must complete the full eight courses within two years of date of hire.

Section I. Competencies

A. Orientation to Mental Health Recovery

A belief in and understanding of Recovery that includes:

Understanding and *using* the ten core principles from the national consensus statement on recovery (hope, self direction, individualized and person-centered, empowerment, holistic, non-linear, strengths-based, peer support, respect, and responsibility) plus resiliency, added by the Washington State Transformation Project.

The history and course of the consumer movement.

The research about the probability of mental health recovery.

An understanding of and a commitment to protect consumers' rights.

Discovering how "recovery" serves the mission and enriches the provider's experience and ability to be present to the people we serve and the work.

B. The Clinical Relationship: Creating A Culture of Respect:

Building a clinical relationship based upon mutuality and partnership.

Understanding the continuum of the recovery process model from unaware disengaged/dependency to aware/interdependency/independence. Ability to engender hope, optimism, and recovery for people at every level of disability, various degrees of insight, and/or various levels of motivation – "dependent, unaware", etc.

The ability to inspire people to assume or resume employment, education, a social life or normalized housing, and to thrive in these roles.

C. Recovery Care Planning

Able to partner with adult consumers and families of children and youth as they direct and design their recovery plan (ISP), including:

- Assisting people to recognize their strengths and to utilize their strengths in implementing their recovery plan;
- Assisting people to explore what recovery means to them and what they need to realize that vision; and

- Assisting people to prioritize and set goals with objectives that are specific, measurable, achievable, realistic and timely.

Encourage and support adults/families/youth to consider each life domain, including housing, education, financial assets, vocation, leisure and recreation, health and wellness (including mental health), intimacy and sexuality, and spirituality.

Able to inspire and support people to use mainstream and personal resources that might meet their needs.

Understand the value of risk taking by adult consumers and staff in order to promote further growth.

Able to promote and responsibly support personal choice even when the clinician doesn't necessarily agree.

D. Documentation of the service process

Documenting the process of service provision in a recovery model that meets sometimes apparently conflicting requirements such as demonstrating medical necessity.

E. Promoting Respect, Dignity and Social Inclusion

Understanding external, institutional and self stigma and the effects on adults, youth, and families

Able to teach and support people to cope with stigma

Able to help them to challenge and overcome discrimination and social exclusion.

F. Cultural Considerations in Promoting Recovery

Understanding how recovery principles might be unique or different in different cultures.

G. Assisting Consumers to develop WRAP and/or Advance Directives

Knowledgeable about WRAP and Advance Directives. Able to support and assist people to develop and implement a WRAP plan. Able to assist people in developing Advance Directives.

H. Understanding Peer Support Services

Understanding the mutually affirming roles of peer support and professional services, including how a peer support specialist differs from a case aide.

I. Employment

Knowledgeable about how to support people to find, get and keep jobs, either directly or as a referral; and if referred, how to support that continued relationship and the person's successes.

J. Working with family (including families of choice)

Understanding the family experience of a family member with a psychiatric disability. Knowledgeable about the effect on roles in a family. Able to encourage and support family/professional/consumer collaboration.

Section II. Foundational Recovery Curricula via Relias Learning (RL)

Agencies may assign the King County (KC) version of the course, which includes a test-out exam (if the learner passes the test-out exam, they get credit for the course,) OR the Relias Learning (RL) version of the course, which gives them CEUs for national accrediting bodies Both the KC and RL versions can be used for state certification CEUs.

<Please note that each of the following four courses (A. through D.) are embedded in a curriculum and it is the curriculum that must be assigned, rather than the course.>

A. RL Curriculum: Path to Recovery (2 credit hours). Addresses: "Competency I: Orientation to Mental Health Recovery."

B. RL Curriculum: Motivational Interviewing (4 credit hours). Addresses: "Competency III: Recovery Care Planning" and "Competency II: The Clinical Relationship: Creating a Culture of Respect."

C. RL Curriculum: Self-Direction, Person-Centered Planning, and Shared Decision Making to Facilitate Recovery – Part 1 (1.5 credit hours) Addresses: "Competency III: Recovery Care Planning."

D. RL Curriculum: Self-Direction, Person-Centered Planning, and Shared Decision Making to Facilitate Recovery –Part 2 (1.5 credit hours) Addresses: "Competency III: Recovery Care Planning."

Please note that each of the following courses are simply courses, and can be assigned as a course.

E. RL Course: WRAP One-on-One (3 credit hours) Addresses: "Competency VII: Assisting Consumers to develop WRAP and/or Advance Directives."

F. Those serving Adults: RL Course: Supported Employment for Social Service Agencies (2 credit hours) Addresses: "Competency IX: Employment."

Those serving Children: RL Course: Strengths-based Perspectives for Children's Services. (1.5 credit hours) Addresses: "Competency I: Orientation to Mental Health Recovery and Resiliency for Children and Families."

G. RL Course: "A Culture-Centered Approach to Recovery" (3 credit hours) Addresses: "Competency VI: Cultural Considerations in Promoting Recovery."

H. RL Course: "Peer Specialists 101: Research, Core Competencies and Ethics" (1 credit hour) Addresses: "Competency VIII: Understanding Peer Support Services."

King County Mental Health Recovery and Resiliency-Oriented Clinical Skills Inventory

The recovery and resiliency-oriented skills and practices described in this inventory are an ideal. All services are to be provided in partnership with persons who have psychiatric disabilities and families of children and youth who have behavioral and mental health challenges. For persons who have psychiatric disabilities and/or who are cognitively challenged due to traumatic brain injury, stroke, or dementia, these skills and practices apply to involved and designated family and friends and/or staff of a residential facility. In all interactions, practitioners endeavor to respect the people and families they are working with and support their sense of personal dignity.

Domains / Skills	**Practices/Behaviors**
I. Interpersonal Competencies	
1. Communicate with persons in order to develop a collaborative relationship	☐ Use interpersonal communication techniques (e.g., reflective listening, paraphrasing, asking facilitative questions, and responding clearly in verbal and non-verbal ways). ☐ Address the whole person, not their disability or diagnosis. ☐ Endeavor to understand a person's subjective experience and reasons for their behaviors. ☐ Endeavor to be fully present, authentic, and caring. ☐ Use person-first language and avoiding the labels and subtle messages professional language has historically conveyed to people living with mental health challenges. ☐ Incorporate the preferred language and communication style as appropriate (e.g., verbal and non-verbal, slang, eye contact, personal space). ☐ Ensure people have full access to their clinical records. ☐ Ensure people can submit and have included comments to correct perceived errors in fact.
2. Use collaborative relationships in order to facilitate personal change	Individualize the following to match the needs, learning styles, and culture of the person and/or families and/or youth: ☐ Establish trust ☐ Reassure ☐ Mentor ☐ Teach ☐ Reward ☐ Support ☐ Guide ☐ Assists people to set goal ☐ Reinforces achievement ☐ Prompt/Remind ☐ Communicate the understanding that the person and/or family is the expert in their own experience and what works and doesn't work for them. ☐ Acknowledge emotions of anger, dissatisfaction, and fear, among others, as norma reactions to circumstances, rather than attributing normal feelings to an illness. ☐ Partner with the person served, collaborating to develop the agenda for each meeting ☐ Connect the client to other needed services.

Domains / Skills	**Practices/Behaviors**
	☐ Partner with the client's other system service providers (as needed and permitted), to minimize duplication and ensure wraparound care provision. ☐ For youth clients; cross-communication and team building with parents/caregivers.
3. Instill hope by engaging in positive interactions (verbal and non-verbal communication) regarding an individual's potential	☐ Engender hope and optimism for people at every level of disability, or degree of insight or motivation, holding hope for the person/family until they are able to do so. ☐ Affirm and celebrates an individual's accomplishments, strengths, and resiliencies. ☐ Validate the person and family's courage, efforts, and persistence, even and especially when they experience setbacks. Recovery is non-linear. ☐ Link strengths and resiliencies to the person's identified goals. ☐ Work in partnership with the person to set and modify measurable and incremental steps toward objectives and goals. ☐ Highlight opportunities to learn from disappointments. ☐ Explain the recovery process, including varying courses, and the findings of long-term outcomes research. ☐ Point out accomplishments of peers and of the consumer movement. ☐ Involve peer support and other positive mentors. ☐ Design recognition activities. ☐ Use self-disclosure appropriately. ☐ Encourage a return to employment and/or education. ☐ For youth clients- collaborate with the client's educational/vocational supports to encourage appropriate modification of their programs or use of supports due to mental health needs. ☐ Support risk taking while assisting the person and/or family to evaluate the possible consequences of their decisions. ☐ Communicate confidence that the individual and/or family will learn illness self-management. ☐ Listen to and affirms people in their vulnerabilities and weaknesses without judgment. ☐ For persons who are facing end of life issues, listens to and assists people with life review, and assists people to connect or reconnect with loved ones.
4. Use motivational enhancement and readiness development strategies to initiate and sustain the recovery process	☐ Assess and develop readiness. ☐ Share information with person served. ☐ Use motivational interviewing techniques including reflecting, affirmation, rolling with resistance, and developing discrepancies. ☐ Facilitate the individual's exposure to and interactions with successful peer and parent peer support specialists.

Domains / Skills	**Practices/Behaviors**
II. Professional Role Competencies	
1. Promote the effectiveness of recovery and resiliency-based services with colleagues and the service delivery system	☐ Inform persons served and if relevant, their families/supports about how they can be involved in recovery planning, implementation, and evaluation at the agency, e.g. participating in a consumer advisory group or a family support group. ☐ Ensure that persons served have an opportunity to learn about the agency's structure, including the governing board and quality management process. ☐ Inform persons served about such opportunities at the system level (e.g. King County Voices of Recovery advisory group). ☐ Encourage colleagues to consider organizational barriers or other obstacles to care before deciding a person served is unmotivated or non-compliant, therefore avoiding an inappropriate assigning of blame to the person, rather than a failure of the services offered. ☐ Encourage the development and exercise of leadership skills in the people who receive services and their participation in the development and evaluation of agency. ☐ Encourage colleagues to actively collaborate and build relationships with self-help and consumer run activities of various kinds. ☐ Encourage flexibility in the location and time services are available to best meet the needs of the persons served. ☐ Encourage minimal coercion, rules, exclusions, "prerequisites, and other hoops to minimize persons "lost to follow-up." ☐ Participate and encourages system collaboration, including community healthcare, criminal justice, housing, etc. ☐ Understand and am able to explain the social model of disability to colleagues and persons served. ☐ Utilize material learned from in-service training. ☐ Impart relevant information about guidelines, best practices, and research at formal and informal staff meetings.
2. Maintain my personal wellness to ensure the effective provision of services	☐ Monitor the level of one's personal stress. ☐ Seek interventions to reduce stress and increase wellness. ☐ Choose appropriate wellness activities.
3. Provides best-practice procedures, treatments, and approaches which help persons and families achieve their goals.	☐ Welcome people into services, into a session, into their own lives, even and especially people who may have been labeled difficult or non-compliant. ☐ See people in the context of their whole selves and lives, not just their illness. ☐ Gather, assess, summarize, and communicate information regarding etiology, course and biological factors of psychiatric disorders and behavioral health challenges. ☐ Communicate rights and legal issues relevant to mental illness and treatment (including the right to change providers). ☐ Advocate for a continued relationship with persons served rather than sequential movement through a pre-existing continuum of care and services that serve the agency rather than the therapeutic relationship. ☐ If clinician change occurs, help the client transition, grieve for or assess their experience of loss/change, and establish trust and a therapeutic relationship with the new clinician. For youth in particular, integrate an awareness of how these shifts can echo or bring up other experiences of loss or attachment transitions.

Domains / Skills	**Practices/Behaviors**
	☐ Partner with the persons served to complete required paperwork, using this process to support the development of recovery and resiliency, recording a person or family's comments verbatim when possible. ☐ Ensure that people who have co-occurring disorders, e.g. substance use, medically compromised, etc. have access to services to address their needs with regard to those issues. ☐ Provide or take advantage of educational opportunities to learn evidence-based and promising practices, including practices used for diverse populations and youth, adults, and older adults.
4. Engage and serve appropriately persons and families who present for services from all the diverse backgrounds (e.g., socio-economic status, race, ethnicity, gender, sexual orientation, age, nationality, disability status, religion, spirituality)	☐ Elicit information about culture from all persons served. ☐ Incorporate cultural factors into the processes of diagnosis, assessment, goals, planning and interventions, including information from cultural consultants if sought. ☐ Uses technique and modalities that match specific cultural parameters. ☐ Makes referral to the appropriate cultural providers and healers, with consultation with the client and/or the client's family/supports. ☐ Use awareness and knowledge of one's own cultural background and assumptions to enhance the collaborative relationship. ☐ Select and use interpreters appropriately. ☐ Incorporate cultural expectations of natural support systems into all aspects of the recovery and resiliency process. ☐ Recognize client behaviors as a result of discriminatory experiences. ☐ Teach coping skills in response to institutional barriers. ☐ Facilitate self-advocacy by teaching persons and families to access services and resources. ☐ Refer clients to community organizations that work to remove cultural barriers and discriminatory practices. ☐ If the client is interested in exploring these issues, help the client determine ways in which they can connect to community, social and/or spiritual supports. Assist youth in exploring their birth/adoptive heritage(s) and determining how they can draw strength from their own or (as possible and appropriate) other cultures/spiritual paths/religions.
5. Seek input and feedback from persons served in order to determine ways of improving services	Obtain input and feedback by using the following ☐ Engage in active listening. ☐ Ask facilitative questions. ☐ Explain information clearly and in ways that is are understandable to the client, taking into account age, culture, and developmental level. ☐ Consider input collected in decision-making. ☐ Assess and address any confidentiality issues. ☐ Meet with and communicate with families and/or significant others (while maintaining appropriate and required confidentiality and privacy laws). ☐ Communicate that issues related to dissatisfaction are open for discussion. ☐ Communicate rights, polices, and procedures for lodging formal complaints and grievances.

Domains / Skills	Practices/Behaviors
6. Recognize one's own role during conflicts with persons served in order to facilitate resolution	☐ Track sequential events in dialogue. ☐ Identify personal contributions to that conflict from the sequence of events. ☐ Identify changes in one's own behavior that contribute to a resolution of conflict. ☐ Facilitate people's access to what they might need to exercise their rights and access to advocacy resources. ☐ Model appropriate methods of non-violent conflict resolution for and with youth.
III. Community Integration	
1. Develop linkages with a wide range of community resources specific to meet the needs and goals of persons and/or families with children and youth with behavioral and mental health challenges	☐ Network with community, educational, and organizational leaders. ☐ Build relationships with key community resource personnel. ☐ Partner with persons and other stakeholders to develop needed resources in the community and address cross-system clients to reduce the number of clients that "fall through the cracks." ☐ Partner with families, Peer Support specialists, and clients in active recovery.
2. Provide information about access to practical and meaningful activities to persons and/or families with children and youth with behavioral and mental health challenges living in their environment of choice	☐ Design and facilitate activities in natural settings consistent with an individual or family's needs, interests and choices. ☐ Proactive in assisting individuals and families to develop meaningful accommodations to achieve success in their environments. ☐ Support parents/caretakers to find safe schools. Address and inquire about bullying and stigma, particularly for youth clients. ☐ Communicate clearly with stakeholders. ☐ Speak on behalf of persons consistent with their wishes and interests.
3. Challenge situations in the community that discriminate against persons and/or families with children and youth with behavioral and mental health challenges	☐ Identify stigmatizing behaviors, events, etc. ☐ Advocate for individuals when inappropriately denied benefits/entitlements. ☐ Negotiate and mediating access to accommodations, benefits/entitlements. ☐ Teach self-advocacy skills to clients and families. ☐ Connect persons with advocacy resources.

Domains / Skills	Practices/Behaviors
4. Link persons with psychiatric disabilities and/or families with children and/or youth with behavioral and mental health challenges to appropriate entitlement and benefit programs	☐ Assess potential eligibility for entitlement and benefit programs; or readily and appropriately refer persons served to resource for such assessment. ☐ Forward appropriate referral information and medical/rehabilitation assessments to entitlement/benefit program as per request in a timely manner. ☐ Provide support as needed to assist persons in obtaining entitlements and benefits, e.g., completing forms, transportation, etc.
IV. Assessment, Planning, Interventions, and Outcomes	
1. Perform holistic assessments across multiple life domains with persons and families in order to identify strengths, supports and barriers, and to ensure symptoms are appropriately addressed.	☐ Encourage people to have physical exams and appropriate screening tests to ensure symptoms are appropriately addressed (e.g. thyroid dysfunction, sleep disorders, malnutrition, allergies, medication effects, etc.). Refer clients to medical providers as needed. ☐ Collaborate with the person in identifying strengths/needs for achieving success in the chosen environment. A discussion of strengths and resiliencies are a central focus of every assessment, care planning session and case summary. ☐ Encourage and support adults/families/youth to consider each life domain, including education, employment, housing, finances, health, recreation, intimacy, sexuality, and spirituality, as developmentally appropriate. ☐ Use appropriate protocols for assessing functional, resource, clinical, and specialty service needs. ☐ Elicit individual's involvement in collecting subjective and objective data, asking simple but powerful questions such as, "What happened? And what do you think would be helpful? And what are your goals in life?" ☐ Share information collected with the person to facilitate understanding. ☐ Collaborate with psychiatric providers, as needed. ☐ Collaborate with the family and/or youth to complete the developmental assessment. ☐ Identify needed supports and potential barriers. ☐ Assume the person is the expert in their own needs having learned much in the process of living with, and working through their struggles. ☐ Inquire about, and be conscious of the past or present role of trauma and trauma-survival in the experience and symptomology of clients.
2. Collaborate with persons and families to identify personal priorities, preferences, resiliencies, strengths and interests in order to help them identify and write goals that are consistent with their worldview	☐ Assess readiness for change. ☐ Conduct values clarification exercises. ☐ Identify multiple pathways for achieving specific goals. ☐ Write plans in understandable language in collaboration with persons served. ☐ Teach goals setting using SMART (Specific, Measurable, Achievable, Realistic, and Time-limited) approach to goal setting in as much as possible. Supports DUMB (Dreamy, Unrealistic, Motivating, and Broad) goals when such a goal is the person's choice as this may be motivating, trusting the person to move to SMART goals when they are ready to do so. ☐ Teach decision-making techniques to assist people to measure the pros and cons of choices they may make. ☐ Assist persons served to link their strengths, resiliencies, goals, and objectives.

Domains / Skills	**Practices/Behaviors**
	☐ Promote and responsibly support personal choice, (even when the practitioner isn't necessarily in agreement,) working with the person, assisting them to consider the pros and cons of their choice. ☐ Help youth clients learn the steps needed to make informed choices, and empower youth clients to make and "learn through" choices. ☐ Assist the individual or family to develop a proactive plan for wellness, which specifies steps to take to maintain wellness, which may be in the context of a WRAP. ☐ Encourage people to include their own personal and cultural healing practices.
3. Encourage persons to continue fulfillment of desired roles (e.g. family member, student, Girl Scout, employee, etc.)	☐ Assist persons and families to recognize their strengths, resiliencies, and interests to explore possible options. ☐ Inspire people to assume or reassume education, employment, a social life, a regularized family role, or normalized housing and to thrive in these roles. ☐ Assist people to find and choose a program model approach that fosters the person's chosen role. ☐ Assist people to participate as full citizens including voting, serving as a juror, engaging in youth clubs/sports, etc. ☐ Assist people to "give back" to the community, i.e. volunteering, neighborhood watch, etc.
4. Facilitate informed decision making by persons with psychiatric disabilities and/or families of children and youth who have behavioral or mental health challenges to help them achieve their goals	☐ Communicate choices to persons and/or families. ☐ Communicate treatment options. ☐ Identify opportunities to develop social supports. ☐ Assist people to access services they might receive to help them choose, get, and keep jobs (Division of Vocational Rehabilitation, Supported Employment Services). ☐ Assist families and/or youth to access services they might receive within the educational system. ☐ Communicate confidentiality regulations to staff, clients, families, and others. ☐ Communicate and apply knowledge about benefits in the areas of housing, education, employment, health, rehabilitation, and disability. ☐ Communicate information regarding rights and ways to have grievances addressed. ☐ Share information with individuals and families relevant to their services, including offering access to their treatment records.
5. Inform people about options in order for them to choose the appropriate types and levels of service	☐ Match the goals of persons and/or families with service options. ☐ Identify service options with the person and/or family. ☐ Provide services with flexibility, including plans to reduce the intensity and intrusiveness of interventions (e.g. payeeships). ☐ Advocate for the development or procurement of new services that will meet the goals of the person and/or family.
6. Integrate natural supports and community resource programs into assessment, planning and outcomes	☐ Assess available natural community supports. ☐ Promote the use of natural support systems. ☐ Provide linkages with natural community support systems. ☐ Complete a resource assessment, a plan and projected outcomes. ☐ Match individual's needs/goals with community resources. ☐ Assist families to access resources they may be entitled to, including Individualized Education Plans for children.

Domains / Skills	**Practices/Behaviors**
	☐ Encourage people/families to consider including family and other supports in care. ☐ Ensure collaboration with medical providers, especially for children and older adults. ☐ Ask youth clients who their supports are, and who they want clinicians to work with—which may be family members or other natural supports (or both).
7. Provide information on alternatives and complementary supports to traditional psychiatric treatment	☐ Locate appropriate informational programs for individuals and families. ☐ Collaborate with persons as to how they can initiate their own alternative programs. ☐ Promote involvement in alternative programs. ☐ Share resources for alternative and complementary supports available in the community. ☐ Facilitate opportunities for people to pursue alternative and complementary supports.
8. Evaluate with the service recipient, his/her satisfaction with progress toward their goals and modifies the plan as indicated	☐ Collect data regarding the achievement of goals. ☐ Assess for changes in needs at regular intervals. ☐ Collaborate to identify alternative objectives and goals. ☐ Collaborate to identify alternative intervention options. ☐ Listen to feedback from persons and families served. ☐ Make requested changes in plans. ☐ Honor person's choice or preference for all alternative plans or modified plans. ☐ Seek to identify signs of organizational barriers or other obstacles to care and address those first when a person or family is not adhering to interventions (e.g., medications).
9. Provide information and support for healthy behaviors and referrals to sources for more information.	☐ Teach positive self-talk. ☐ Assist people to assess their diet, exercise, and balance of solitude and relationship and make changes when they are ready to do so, including offering resources to support changes. ☐ Assist people to reestablish relationships that may be broken, including families and children ☐ Assist people to have pets. ☐ Assist people to personalize their homes and establish priorities and methods to maintain their home as a healthy environment. ☐ Address sexuality and family planning, with feedback/permission from parents for youth clients under age 13. ☐ Avoid assuming the client's sexual orientation, and avoid assuming that the client's sexual orientation, gender, or partner choice is immutable. ☐ Assists people to establish intimate relationships, if this is a goal. ☐ Support people to explore spirituality as a resource for healing and comfort.
10. Teach communication skills to help persons and families achieve their goals	☐ Write skill acquisition plans in understandable language that incorporates the person's and/or family's voice. ☐ Assist persons to choose the relevant skills to improve. ☐ Teach specific communication skills. ☐ Demonstrate/model communication skills. ☐ Arrange with the individual opportunities for skill practice. ☐ Give useful feedback on skill performance.

Domains / Skills	Practices/Behaviors
11. Teach problem-solving skills to help persons and families achieve their goals	☐ Assist the individual and/or family in defining problems. ☐ Generate alternative solutions. ☐ Write problem solving plans in understandable language that incorporates the person and/or family's voice (quotes are preferable). ☐ Explain problem-solving steps in understandable language. ☐ Explain steps in understandable language to others who are assisting in the plan.
12. Use outreach techniques, including telephone, mail, and personal visits, in order to engage persons and families in interventions	☐ Determine that the outreach is needed. ☐ Choose outreach techniques based on the individual's and/or family's needs and preferences. ☐ Identify strategies to locate individuals who are disengaged – areas they have been known to frequent, other agencies or organizations that might know where the person might be found, etc. ☐ Choose engagement techniques based on needs and preferences. ☐ For youth clients, go to where the youth client is and needs support—whether that is the home, the school, or other locations.
13. Develop relapse prevention strategies for mental and physical health and co-occurring disorders in partnership with the person and/or family	☐ Assess changes in psychiatric symptoms. ☐ Assess changes in behavior or appearance that may be indicative of relapse. ☐ Assess concerns about psychiatric symptoms. ☐ Assess the presence of other concerns (e.g. medical). ☐ Link appropriate psychiatric, substance use, and medical services. ☐ Conduct follow-up of referrals to collaborative providers. ☐ Develop a proactive plan for wellness with the individual which specifies steps to take to maintain wellness and prevent relapse, which may be in the context of a WRAP – use with youth clients, and use age-appropriate language. ☐ Encourage people to include their own personal and cultural healing practices.
14. Collaborate with persons and families to help them identify their individual preferences in dealing with crises	☐ Facilitate the individual or family's choice of preferences for dealing with crises. ☐ Ask about client and family successes- times they have gotten through challenging situations, and build on the client and family's strengths and resiliencies. ☐ Identify and teach coping strategies and skills, including skills to cope with voices (sometimes called auditory hallucinations). ☐ Develop a proactive plan with the individual which specifies steps to take in a crisis, which may be in the context of a WRAP and/or an Advance Directive. ☐ Encourage people to include their own personal and cultural healing practices.
15. De-escalate crises experienced by persons with psychiatric disabilities in order to avoid negative outcome	☐ Maintain a calm demeanor. ☐ Reassure persons that they will receive that they need. ☐ Remind the person of their personal, proactive plan which may be a WRAP and/or Advance Directive, following their preferences whenever possible. ☐ Persuade persons to receive services and/or take medication by trying different ways to engage them that respect their ability to make choices on their own behalf. ☐ Accompany persons to needed services or supports when possible. ☐ Involve appropriate providers, healers, family members, friends, religious representative. ☐ Assess level of functioning stability, risk. ☐ Develop a plan for implementation of crisis stabilization services. ☐ Follow procedures for voluntary and involuntary hospitalization.

Domains / Skills	Practices/Behaviors
	☐ Advocate for the person's Advance Directive. ☐ Use methods to inform of the effect of their behaviors. ☐ Use direct instruction to guide behavior. ☐ Apply appropriate de-escalation techniques. ☐ Access resources for a psychiatric emergency, transportation, police, hospitalization, respite and diversion services.
16. Identify opportunities that empower persons or families with children and/or youth to transition from professional provider service to natural community supports and life in the community	☐ In partnership with the person and/or family, develop criteria for reducing the intensity of services and exiting agency services that are clearly defined and discussed on a periodic basis. ☐ Avoid reducing services "because they're working" unless a client is clearly engaged in an alternative support that is working at least as well as the formal support they are transitioning from. ☐ Facilitate connectedness to natural support systems. ☐ Encourage persons and families to use natural support systems. ☐ Identify useful natural supports. ☐ Collaborate with natural support systems. ☐ Assess necessity with the individual for other professional provider services.

Sources:

A Recovery Based Program Inventory by Mark Ragins, M.D. www.village-isa.org

New Zealand Mental Health Commission (2002) Recovery Competencies for New Zealand Mental Health Workers

Practice Guidelines for Recovery-Oriented Behavioral Health Care. Prepared for the Connecticut Department of Mental Health and Addiction Services by the Yale University Program for Recovery and Community Health (Tondora & Davidson, 2006)

Recovery Self-Assessment (RSA). O'Connell, M., Tondora,J., Croog, G., Evans, A., & Davidson, L., Yale University School of Medicine

U.S. Psychiatric Rehabilitation Certification Exam Blueprint, Becoming a Psychiatric Rehabilitation Practitioner https://uspra.ipower.com/Certification/CPRP_Exam_Blueprint_2009.pdf

Youth and Family Consensus Statement on Resiliency and Children's Mental Health, 2008, Resiliency Leadership Ohio and Ohio Department of Mental Health

XI. CREDENTIALING AND CONTRACT MONITORING

1.0 POLICY TITLE: CREDENTIALING AND CONTRACT MONITORING

1.1 Originally Implemented: November 1, 1995

1.2 Reviewed and revised: November 2014

1.3 Officially Adopted: January 2, 2015

1.4 Effective Date: February 2, 2015

1.5 Signed: _____
Jean Robertson, Assistant Division Director/RSN Administrator

2.0 PURPOSE: To specify the requirements for credentialing, re-credentialing, and contracting with providers to provide outpatient community mental health services and to specify the means for monitoring provider contracts to ensure the highest quality of care and service delivery.

3.0 POLICY/PROCEDURES/RESPONSIBILITIES:

3.1 Policy

3.1.1 Credentialing Minimum Requirements – Providers and Subcontractors

A. The King County Mental Health Plan (KCMHP) shall ensure that members of the provider pool, including any clinical and/or non-clinical subcontractors, meet each of the following minimum credentialing and re-credentialing requirements:

1. Hold a current or provisional Department of Social and Health Services (DSHS) Community Mental Health Center License or other license, which covers the services to be provided. The provider shall be in good standing with the licensing agency and be able to provide all appropriate services to the populations it serves. The provider shall notify the KCMHP of any changes in status for any required licensure or certification; and

2. Can demonstrate the ability to provide appropriate services to adults, older adults, and/or children, for which they are contracted to serve by the KCMHP or by the provider in the case of a subcontractor.

B. Can provide copies of the provider's or subcontractor's current professional liability insurance.

1. Provider and subcontractors shall procure and maintain insurance against claims for injuries to persons or damages to property that may arise from, or in connection with, the performance of work hereunder by the provider, its agents, representatives, employees, and/or subcontractors.

2. Provider shall ensure that its subcontractors have insurance that complies with the requirements stated in the provider's contract with KCMHP. The costs of such insurance shall be paid by the provider or its subcontractor. Provider shall furnish separate certificates of insurance and policy endorsements which list KCMHP, the County, its officers, officials, employees, and agents as additional insured's for itself and each subcontractor as evidence of compliance with this section.

3. In cases where there is no formal subcontract, yet payment for direct services is provided, providers shall have a blanket-type coverage statement in their policy for occasional workers or casual labor in order to adhere to the requirements of their contract.

4. Providers, who expect to hire an individual to provide periodic service over an extended period of time, may write a basic service agreement with that person as long as it adheres to KCMHP standard contract terms. Multi-year agreements are acceptable. The provider shall be clear in the agreement as to tax liability (issuing an IRS 1099) if the person with the agreement receives over $600 in a calendar year. All persons with service agreements shall undergo a full background check.

C. Can demonstrate:

1. An acceptable history of malpractice findings within the past five years;

2. Unrestricted Drug Enforcement Agency (DEA) prescriptive authority licenses for physicians and documentation of prescriptive authority for all Advanced Registered Nurse Practitioner (ARNP) staff who prescribe medications;

3. It is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in any federal health care plan;

4. Unrestricted current professional license for all physicians, ARNPs, LPNs, RNs, and any other form of professional licensure that relates to the services being provided by the provider or its subcontractor;

5. For services for which state or federal law require licensure, those providing service shall be licensed by the proper DSHS department/agency or other appropriate state or federal agency. Verification of provider and subcontractor license shall be on-site and a copy provided to the KCMHP, if requested;

6. For activities that must be performed by a psychiatrist, the psychiatrist is either:

    a. Board certified, or

    b. Board eligible, meaning the physician has completed a psychiatry residency approved by the Accreditation Council for Graduate Medical Education, as noted on their website at www.acgme.org;

7. It can provide 24-hour crisis services that meet the requirements in Section V. The documentation submitted shall describe the crisis services structure and in addition shall include:

    a. The scope of work for subcontracts for any crisis functions; and

    b. The strategy for quality management of crisis services;

8. An acceptable history of unresolved provider sanctions by Medicare and/or Medicaid;

9. A sound financial position based on the provider's most recent audited financial reports and "Revenue and Expenditure Reports" (see Section IV, Financial Management), including financial tests on liquidity, solvency and efficiency;

    a. A provider shall be considered liquid if the ratio of current assets to current liabilities is greater than one.

    b. A provider shall be considered insolvent if unrestricted net assets are less than 5 percent of annual revenues for two or more consecutive years.

    c. A provider shall be considered financially efficient if the calculated ratio of direct service costs to total Regional Support Network/KCMHP related expenses is greater than 90 percent.

    d. A significant change or reduction to income or expenses shall be reviewed to see if mental health services to clients have been adversely impacted;

10. Efforts to ensure data quality either through a proven record of data quality and accuracy or, for new providers seeking to be credentialed, proof of ability to technically interface with the King County Mental Health, Chemical Abuse and Dependency Services Division Information System (MHCADSD IS); and

11. Satisfactory performance related to the system accountability measures and the clinical performance measures identified in Section X, Quality Management, this section, and the provider's contract.

D. Provider and subcontractors shall abide by the requirements of Section 1128A(b) of the Social Security Act prohibiting service providers from making payments directly or indirectly to physicians or other providers as an inducement to reduce or limit services provided to recipients.

E. All service providers and subcontractors shall be credentialed by the KCMHP through the normal credentialing process.

3.1.2 Provider and Subcontractor Credentialing/Re-credentialing

A. The KCMHP shall conduct credentialing and re-credentialing for providers and subcontractors prior to contracting for the ensuing year.

B. Providers shall not use subcontractors who have not been credentialed by the KCMHP. Under special circumstances, the provider shall contact the KCMHP for a temporary exception to policy.

C. Credentialing requirements may be amended over time and current credentialed providers and subcontractors may be required to update their standards or provide additional information.

D. The KCMHP may add licensed providers to the existing contract pool as needed to provide capacity and quality outpatient clinical services. The decision to add providers shall be based on information from data, quality assurance reviews, capacity, client needs, and service area requirements. The KCMHP shall notify any provider asking to be added to the network of the reason for not being selected for the authorized provider network.

3.1.3 Credentialing Provider Subcontractors

Upon approval by the KCMHP, providers may enter into subcontracting relationships with other providers in order to expand their KCMHP service capabilities if those subcontractors have been credentialed by the KCMHP.

3.1.4 Contract Monitoring and Management

The KCMHP shall provide ongoing monitoring of clinical, administrative, and system-wide indicators to ensure that the provider:

A. Is in compliance with KCMHP policies and procedures as defined in this manual and contract requirements;

B. Provides mental health services only in those areas it is licensed to provide and which comply with generally accepted and culturally relevant minimum requirements and guidelines as set by the KCMHP;

C. Exhibits practice patterns which are consistent with the values and goals of recovery;

D. Provides care and service delivery to the satisfaction of clients; and

E. Meets credentialing indicators for its professional staff.

3.1.5 Provider Profiles

The KCMHP shall develop provider profiles for the purpose of demonstrating:

A. The scope of the KCMHP service delivery system; and

B. The performance of individual providers in meeting identified service system goals.

3.1.6 Complaints

The KCMHP shall provide a complaint/inquiry resolution process for issues or complaints directed at contract providers.

A. For complaints initiated by clients about providers, see Section III, Client Rights.

B. For complaints initiated by providers about KCMHP administration, see Section VI, Outpatient Services Level of Care.

3.2 Procedures

3.2.1 Provider and Subcontractor Credentialing/Re-credentialing

A. The credentialing process shall provide a means of evaluating, selecting, and contracting with qualified mental health providers for the purpose of providing services under a publicly funded managed care program.

B. KCMHP shall conduct the credentialing of contracted mental health providers. A credentialing application packet shall be sent to all contracted providers in the fall of each calendar year.

1. Direct contracted providers shall submit to KCMHP and retain in their records for subcontractors, subject to review, a complete application packet. The packet shall include:

a. A copy of the subcontractor's confidentiality policy;

b. A copy of the contract or agreement between the provider and subcontractor;

c. A copy of appropriate licensure;

d. A copy of insurance coverage;

e. Provider policies and procedures, or plans, regarding KCMHP requirements as may be identified as necessary for the credentialing period;

f. Certification from direct contracted providers that all required credentialing documents for the provider's subcontractors have been received, reviewed, and approved. Those documents shall be maintained by the direct contract provider; and

g. Copies of the language in the orientation materials for clients that indicate if the provider has any moral or religious objections/restrictions in regards to the care provided (e.g., abortion, end-of-life counseling). This information need only be provided if the provider has moral objections/restrictions with regard to care provided.

2. Contracted providers that elect not to participate in the credentialing process shall not be eligible to contract with KCMHP during the subsequent contract term.

C. Non-KCMHP providers may apply any time during the year by completing an application packet.

3.2.2 Providers shall have 30 days from the date the forms are mailed, unless otherwise specified, to complete the credentialing documents. At the sole discretion of KCMHP, non-contracted mental health providers may have longer than 30 days to complete the application packet.

3.2.3 KCMHP may require a site visit for any provider applying for credentialing. All non-contracted mental health providers that are applying for the first time shall participate in a site visit. All site visits of a provider and/or its subcontractors are conducted following submission and review of a completed credentialing application form.

3.2.4 Completed applications are reviewed by KCMHP. Providers that:

A. Meet the KCMHP standards shall be offered a contract for review and signature.

B. Do not meet the credentialing standards may receive provisional contract status in the network and a contract may be extended.

C. Serve high-risk populations or specialize in conditions that require costly treatment will not be discriminated against by KCMHP in its application review process.

D. Are acting within the scope of their license or certification under applicable State law shall not be discriminated against by KCMHP in its application review process in regards to the provider's participation, reimbursement, or indemnification based solely on that license or certification.

3.2.5 KCMHP shall retrospectively query the State of Washington to verify Drug Enforcement Agency (DEA) certificate status, licensure, certification, and registration status of all Medical Doctors (MDs) and Advanced Registered Nurse Practitioners (ARNPs) and other clinicians. Because of the time needed to verify this information, contracts may be executed prior to verification from the state. If KCMHP is notified that a clinic/practitioner is not registered, certified or licensed and/or has a license/DEA restriction, KCMHP reserves the right to terminate the provider agreement or place limitations on the scope of practice performed by the clinic/care provider. Should this occur, providers would be notified in writing by KCMHP.

3.3 Credentialing Provider Subcontractors

3.3.1 Upon approval by KCMHP, providers may enter into subcontracting relationships with other providers in order to expand their service capabilities.

3.3.2 Providers shall submit to KCMHP the required application and forms on behalf of the subcontractor. Certain policies and procedures regarding KCMHP requirements as may be identified as necessary for the credentialing period shall be retained by the direct contracted provider and are subject to KCMHP review. Upon County request, the provider shall submit:

A. Copy of the subcontractor's confidentiality policy;

B. Copy of the contract or agreement between the provider and subcontractor;

C. Copy of appropriate licensure; and

D. Copy of insurance coverage.

3.3.3 Applications shall be completed for all subcontractors during annual provider re-credentialing. Subcontractors can be approved as part of the credentialing process or subcontracts with a start date after the credentialing deadline may be submitted for separate consideration.

3.3.4 Providers' responsibilities related to their subcontractors are as follows:

A. The provider shall ensure that all licenses are current and that the licensee is in good standing with the licensing agency;

B. The provider shall require the subcontractor to abide by all the requirements of this manual and the provider's agreement with KCMHP. To this end the provider shall be responsible for sharing this information with the subcontractor, including providing a copy of this manual and any updates which occur during the term of their agreement;

C. The provider and the subcontractor shall hold harmless KCMHP;

D. The provider shall ensure that the subcontractor:

   1. Provides mental health services only in those areas it is licensed to provide and which comply with generally accepted and culturally relevant minimum requirements and guidelines as set by the KCMHP;

   2. Provides care and service delivery with a recovery focus and to the satisfaction of clients; and

   3. Meets credentialing indicators for its professional staff;

E. Provider shall provide documented supervision or monitoring of the subcontractor to ensure compliance with the requirements for subcontractors under the provider contract with the KCMHP;

F. If subcontracts are with non-KCMHP providers, such subcontracts shall be reviewed to ensure, at a minimum, that any and all Title XIX-defined clinical services that are contracted for reimbursement are provided by agencies that have a current or provisional Title XIX license to provide those contracted services;

G. Non-licensed subcontractors of clinical services must have documentation that an application for a Title XIX license for the services they are contracted to provide has been submitted to DSHS. This application shall be approved by KCMHP. The licensed contracting provider must assure the KCMHP that it shall provide clinical supervision to the non-licensed subcontractor comparable to its own in-house supervision, at least until a provisional license is issued;

H. Subcontractors of non-clinical KCMHP services shall also be credentialed;

I. A licensed provider that subcontracts with an individual for KCMHP services shall do so under the aegis of the provider's license, assuming he/she is fully covered under the provider's professional liability policy. This is not necessary if the individual has independent professional liability insurance that meets the requirements;

J. The provider may request an Exception to Policy to hire a contract employee for services not normally available within the KCMHP. Any contracted employee shall be fully licensed to provide the services contracted for in her/his subcontractor agreement with the provider and be fully covered under her/his own professional liability insurance or be listed as an additional insured under the provider's professional liability insurance; and

K. Providers shall perform an annual site visit to monitor provisional services.

3.3.5 Provider office closures

A. Providers shall have internal procedures, available for review and approval by the KCMHP that address minimum requirements for client care in the event of either a planned or an emergency office closure.

Provider shall ensure the following are available:

1. 24-hour crisis response for authorized clients;
2. Client and network notification procedures;
3. Answering machine message regarding closure and options for clients who call on a closed day; and
4. Specific network instructions on procedures related to unplanned closures due to disaster, inclement weather, etc., and how to reach on-call staff (telephone and pager numbers).

B. All providers shall publish and submit to the KCMHP an annual planned closure schedule at least one month preceding the first closure for the calendar year. Additions to the planned closure list shall be faxed to the Crisis Clinic, DMHPs, and KCMHP no less than two weeks prior to any planned closure.

C. For unplanned closures due to disaster, inclement weather, etc., the internal procedures referenced above shall be followed.

3.3.6 Contract monitoring review for compliance with administrative requirements and clinical review for outpatient, residential, and crisis services

A. KCMHP shall be responsible for reviewing agency compliance with both standard contract requirements and the administrative requirements included in contract exhibits.

B. For KCMHP contractors and subcontractors, administrative records may be reviewed to ensure compliance with contract requirements including and not limited to:

1. Policies and procedures;
2. Personnel files;
3. Accounting records;
4. Pursuit of third-party revenues;
5. Governing Board bylaws and minutes;
6. Memoranda of Understanding; and
7. Agency records of their reviews of subcontractors.

C. KCMHP shall be responsible for clinical review of sample cases as follows:

1. For outpatient services, a random sample of cases;

2. For residential and crisis services, a random sample of cases; and

3. A focused sample based on specific clinical flags, quality management indicators, and/or indicators for compliance with state and federal requirements.

D. At a minimum, reviews of the documentation in the clinical record may include and are not limited to:

1. Determining the accuracy of the benefit assessment and appropriateness of the benefit placement based on all elements of medical necessity, including service intensity;

2. Ensuring that minimum requirements, including all Chapter 388-877A Washington Administrative Code (WAC) requirements or its successor, are met:

a. For crisis services, ensuring that response time and documentation requirements stated in Chapter 388-877A-WAC or its successor are met;

b. For outpatient services, ensuring that initial individual service plan (ISP) development and ISP review and update timelines are met as stated in Chapter 388-877A WAC or its successor; and

c. For residential treatment, ensuring that the treatment setting is the least restrictive alternative, as stated in Chapter 388-877A WAC or its successor.

3. Ensuring attention to diagnostic guidelines;

4. Ensuring appropriate development and monitoring of ISPs for clients (see Definitions) that are comprehensive; that are age, culturally, and disability competent; that address needs identified at intake and annual assessment as prioritized by the client (or family in the case of children) and by clinical need; that incorporate client strengths, voice, and goals; and that prescribe appropriate service intensity;

5. Ensuring participation by the client, family, and significant others where appropriate;

6. Monitoring and ensuring that provider-based ISP reviews are conducted and documented;

7. Reviewing progress and summary of interventions to date towards individual and system treatment and recovery outcomes and goals;

8. Reviewing summary of strategies and interventions planned to achieve outcomes in the forthcoming period;

9. Ensuring consultation with provider staff responsible for clinical oversight;

10. Ensuring consultation by mental health specialist(s) as required by WAC 388-865-0260 or its successor and documentation that the mental health specialist(s) recommendations were incorporated into the clinical record.

    a. Assessments use cultural norms in differential diagnosis and other evaluations;

    b. Service planning incorporates the client's beliefs and traditional interventions where appropriate;

    c. Within 30 days of assessment/intake for new benefits;

11. Ensuring documentation showing that interpreters have been appropriately present during assessments and treatments;

12. Ensuring that providers have effective quality management practices in place to review and improve care;

13. For outpatient providers with clients in supervised living, review coordination and communication with supervised living providers as appropriate; and

14. Validating MHCADSD IS data received from the provider agencies during the period being evaluated to ensure that the case record demonstrates evidence that the demographic, intake, and service entry data are consistent.

E. Clinical reviews may be conducted by telephone or paper facsimile or during a site visit.

1. Telephone or Facsimile Based Reviews: KCMHP shall telephone the provider to review programmatic requirements or individual cases with the appropriate provider staff. The provider is responsible for communicating the required program information, or clinical information (Section VI, Outpatient Services Level of Care; Section VII, Residential Services Level of Care) to KCMHP.

2. Site Visit Chart Reviews: The Annual Site Visit instruments shall be sent to the provider with the 30-day site visit notification letter. Providers shall be given three business days' advance notice of the charts to be reviewed. Notification shall include the King County ID number of each case to be reviewed. It is expected that each identified client's clinical record shall be available to the reviewers at the time of the site visit and that a room shall be set aside for the reviewers.

F. The KCMHP review shall focus on the comprehensiveness and appropriateness of the ISP in relationship to the assessment, attention to standards of care guidelines, the apparent quality of the care provided, accuracy of diagnosis, service intensity, and progress towards or attainment of outcomes as documented in the clinical record.

G. Reviews and analysis of findings shall depend solely on documentation easily and readily available in the client record(s) provided to the reviewer(s). Additional information provided by staff shall be helpful and shall not take the place of or mitigate absent written documentation.

H. Documentation of findings shall occur as follows:

1. Clinical information collected in a telephone or facsimile-based review shall be documented into the MHCADSD IS case notes;

2. For a site visit review, a brief summary of major findings and impressions may be presented following the close of the review. A written report of the findings, impressions and recommendations, as well as a copy of the completed assessment tool, shall be sent to the provider within 30 business days; and

3. KCMHP recommendations may fall into three categories:

a. Case-specific recommendations related to the level of care placement decision, assessment, and/or ISP of an individual client and data accuracy;

b. Recommendations to the provider regarding an identified pattern or trend in providing care agency-wide; and

c. Recommendations to the provider related to the administrative review.

I. KCMHP shall take appropriate action based on its findings from clinical reviews. Where corrective action is indicated, KCMHP shall follow-up to ensure providers have taken steps to make the required changes and/or employed the required alternatives.

J. For case-specific follow-up, a review by KCMHP may be scheduled on a predetermined date (e.g., one month, three months from the time of the clinical review, or sooner if the situation merits immediate attention).

K. Where an agency-wide finding of non-compliance has been made:

1. Corrective action shall be pursued as per description later in this section;

2. Findings and recommendations shall be discussed at follow-up reviews or credentialing and objectives shall be set for the following year. KCMHP may, as a result of a finding, increase or decrease the level of monitoring; and

3. In cases where WAC requirements have not been met, KCMHP may forward the findings to the State.

L. The process for requesting an appeal of a decision regarding a benefit assignment made during a telephone or facsimile based review visit by KCHMP is detailed in Section VI, Outpatient Services Level of Care.

M. The process for requesting an appeal of a decision regarding a benefit assignment made during a site visit by KCMHP is detailed in Section VI, Outpatient Services Level of Care.

3.3.7 Contract monitoring and management

A. KCMHP shall monitor provider performance to ensure quality of care to clients, delivery of appropriate services, and adherence to contract requirements.

B. The KCMHP shall work with individual providers to address specific performance issues. Continued inability to meet performance expectations or to comply with corrective action may lead to further sanctions and ultimately contribute to a decision by the KCMHP not to re-credential the provider.

C. Noncompliance: If KCMHP determines that a provider is in breach of contract (i.e., has failed to comply with any terms or conditions of the contract, including WAC and Revised Code of Washington (RCW) requirements, or has failed to provide the work or services agreed to in the contract), or if provider has failed to respond to requests within specified time frames, action shall be taken consistent with the terms in the Standard Contract (“Boilerplate”) of the agency’s KCMHP Contract.

D. Dollars are at risk for failure to comply with contracted performance targets. Targets shall be developed with stakeholder input.

E. KCMHP shall maintain individual provider files, including correspondence, credentialing, and grievance/complaint information.

F. KCMHP shall undertake an annual review of required state and DSHS reporting forms as required by law.

G. Provider monitoring shall be an ongoing process. Trends that develop for individual provider(s) and on a system-wide level shall be analyzed and reported as appropriate.

3.3.8 Provider profiles

A. KCMHP shall develop a profile of each provider that shall include services, service area, populations served, and licensure/certification of professional staff.

B. The profile shall compile information about each provider and its subcontracts including, and not limited to, addresses, types of services, and access numbers.

C. Data shall be acquired through information received in the credentialing materials and through information in the MHCADSD IS and in the clinical and administrative reviews and site visits.

3.3.9 Resolving provider inquiries and complaints

A. KCMHP shall ensure a timely, professional response to provider inquiries and provide a means of communicating effectively with providers so that issues can be documented and resolved.

B. KCMHP staff who receive complaints about providers shall forward that information to the appropriate contract monitor for follow-up.

C. Complaints among providers within the KCMHP network shall be handled as follows:

1. Complaints of this nature shall be made in writing and are to be referred to KCMHP;

2. KCMHP shall attempt to resolve the issue;

3. KCMHP shall notify the appropriate provider that a complaint has been made against them;

4. KCMHP shall include complaints in corrective actions; and

5. KCMHP shall provide feedback to complainants once complaints have been resolved.

4.0 REFERENCES:

Federal Law, Regulations, and Policy including any successor, amended, or replacement laws, regulations**,** or policies

- 42 Code of Federal Regulations (CFR) Part 438 Managed Care (as revised by the Balanced Budget Act (BBA) of 1997)

- 42 CFR Parts 400, 430, 431, 434, 435, 440 (other regulations regarding Medicaid revised by the BBA)

- 45 CFR Part 142 Security and Electronic Signature Standards (Health Insurance Portability and Accountability Act (HIPAA) “Security Rule”)

- 45 CFR Parts 160 and 164 Standards for Privacy of individually Identifiable Health Information (HIPAA, "Privacy Rule")
- 45 CFR Part 162 Health Insurance Reform: Modifications to Standards for Electronic Transactions and Code Sets (HIPAA "Transaction Rule")
- Federal Executive Order #12549

Washington State Law, Regulations, and Policy including any successor, amended, or replacement laws, regulations**,** or policies

- Chapters 388-865, 388-877, 388-877A WAC – Department of Social and Health Services – Mental Health – Community Mental Health and Involuntary Treatment Programs
- Chapter 70.02 RCW – Public Health and Safety – Medical Records – Health Care Information Access and Disclosure
- Chapter 71.05 RCW – Mental Illness – Mental Illness
- Chapter 71.24 RCW – Mental Illness – Community Mental Health Services Act
- Chapter 71.34 RCW – Mental Illness – Mental Health Services for Minors
- Federal 1915(b) Waiver Renewal

Other

- The Department of Social and Health Services (DSHS) State Mental Health Contract and any subsequent amendments
- The Department of Social and Health Services (DSHS) PIHP Contract and any subsequent amendments

XII. INFORMATION MANAGEMENT

1.0 POLICY TITLE: INFORMATION SYSTEM MANAGEMENT

1.1 Originally Implemented: April 1, 1995

1.2 Reviewed and revised: November 2014

1.3 Officially Adopted: January 2, 2015

1.4 Effective Date: February 2, 2015

1.5 Signed: _____
Jean Robertson, Assistant Division Director/RSN Administrator

2.0 PURPOSE: To define the requirements for collecting, maintaining, and reporting client and service data to support the administrative operation, management decisions, clinical operations, utilization analysis, and system performance of the King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD), Regional Support Network (RSN), and Mental Health Plan (MHP).

3.0 POLICY/PROCEDURES/RESPONSIBILITIES:

3.1 Policy

3.1.1 Configuration of the Mental Health Information System

A. "Information System" refers to the management of an integrated network of databases, structures, and applications to support operations and management.

B. The Mental Health Information System (MHIS) refers to the total electronic information system and network used by the state, KCRSN/MHP, and contract providers to collect, store, and disseminate information concerning client participation in mental health services.

C. The MHIS consists of the following information systems (see Definitions for descriptions of each):

1. DSHS ProviderOne;

2. MHCADSD Information System (MHCADSD IS); and

3. King County provider information systems located at each provider site, which contain client, staff, and service information.

D. The following networks support the MHIS:

1. MHCADSD Local Area Network (LAN), maintained by the KCMHCADSD at the main MHCADSD office and remote business offices. These LANs are connected to the County Wide Area Network (WAN) behind a firewall that limits traffic into the MHCADSD system;

2. The WAN provides e-mail services and links to the Internet and the Government Trusted Network (GTN) through a County firewall;

3. GTN provides secure linkage between state and local governments in Washington including MHCADSD access to the state Regional Support Network (RSN) Demographic Search; and

4. Remote SSL VPN access to the County WAN allows providers to access the MHCADSD IS.

3.1.2 Data Provider

A. Data providers include all providers responsible for directly providing, or responsible for overseeing the provision of, services to clients authorized to receive inpatient, outpatient, or residential levels of care or carve-out program services. This includes providers providing screening, assessment, authorization, and care management services.

B. Types of data providers covered under these policies include community mental health centers, inpatient facilities, evaluation and treatment facilities, King County Crisis and Commitment Services and other entities under contract with the RSN or the KCMHP to provide direct or administrative services.

C. The provider holding the authorization for level of care or carve-out program shall be responsible for meeting all data requirements.

D. When two or more data providers are providing outpatient services, the provider holding a case-rate authorization, a Long Term Rehabilitation (LTR) authorization, or a Homeless Outreach, Stabilization, and Transition (HOST) case-management authorization shall be deemed the data provider for the purposes of maintaining client data accuracy.

3.1.3 Data Provider Requirements

A. All data providers shall have at least the following basic management capabilities:

1. Collect, document, report, and maintain data on clients and services provided;

2. Collect, document, report, and maintain staff data;

3. Establish and maintain the capability for technical interface with the MHCADSD IS and provide regular daily transmissions of data in the format specified in MHCADSD IS policies and procedures;

4. Maintain current, complete, and accurate information in the MHCADSD IS through regular review, audit, and correction;

5. Respond to reports and data processes as required and necessary. See "Provider Technical Reference" (available online to authorized users);

6. Maintain data quality; and

7. Maintain data security.

3.1.4 Data Security

Providers shall develop and implement policies and procedures to ensure the security of information systems data and the confidentiality of client records. See Section XIII, Security of Information Systems Data and Client Records.

3.1.5 Data Collection

A. Providers shall collect, maintain, and report all client and services data according to the requirements in this section.

B. Registration is completed with the reporting of the required demographic and service data elements to the MHCADSD IS.

C. KCMHP programs are grouped in levels of care for the purpose of data collection. Data elements required for collection for each level of care are listed in "Data Dictionary Summary of Attributes (Attachment A) and detailed in "Data Dictionary Provider Transactions" (Attachment B) to this section.

D. There are two types of required data sets that shall be collected by KCMHP providers:

1. Reported Data Set – those data elements that describe clients, services, facilities, and staff that providers are required to collect and electronically report to the MHCADSD IS as described in "Data Dictionary Summary of Attributes" (Attachment A) and in "Data Dictionary Provider Transactions" (Attachment B) in this section; and

2. Extended Data Set – those data elements that providers are required to collect and maintain in provider records.

a. Reporting requirements for the extended data set vary according to the elements. Some elements shall be regularly reported to the KCMHP in aggregate form.

b. In order to support file reviews, all elements shall be documented and maintained in provider records as described in this section and in "Data Dictionary Provider Transactions" (Attachment B).

E. Specific source documentation requirements for each attribute are described in "Data Dictionary Provider Transactions" (Attachment B). If a source document is not specified, the provider shall record the document(s) or other means used to verify client or services information as reported.

3.1.6 Data Reporting

A. Clients enrolled in KCMHP services shall be reported within 72 hours of enrollment.

B. A data element is considered reported to the MHCADSD IS only when recorded in the master tables of the MHCADSD IS and time recorded in the post-date field (see Definitions).

C. The KCMHP shall accept a person enrolled in KCMHP services as reported within these timelines if the provider has met the requirements for assessment data reporting in "Data Dictionary Summary of Attributes" (Attachment A).

D. Providers shall report data elements by means of electronic transmission of batches or through direct online data entry of those elements, in accordance with the format and manner described in this section, to ensure that the data is successfully posted to the MHCADSD IS. See also the "Provider Technical Reference" which is available as an electronic download.

E. Providers shall ensure all transactions have valid form and content before submission to the MHCADSD IS. Transactions rejected by the system for invalid form or content are not posted to the database and are not considered reported. The valid form and content for transactions are described in "Data Dictionary Provider Transactions" (Attachment B).

F. MHCADSD IS shall not change or delete data reported by data providers except:

1. At the specific written request of the data provider; or

2. Where the data reported poses a danger to the integrity of data reported by other providers.

a. All changes or deletions to provider reported data shall be reported to the affected provider(s) within two business days.

b. All data elements entered shall be identified as reported to the MHCADSD IS by the data provider. The data provider and/or staff identifier and date and time of posting shall be recorded as part of the data submission.

3.1.7 Data Timeliness

A. Each attribute shall be collected and reported to the MHCADSD IS at specific times as described in the "Frequency" section of the transaction the attribute is under. (See Attachments A and B in this section.)

B. Providers shall ensure that required data has been successfully posted to the MHCADSD IS by midnight on the required date. Posting by the MHCADSD IS may take up to 24 hours from the time of data submission by the provider.

1. The payment data set shall be reported to the MHCADSD IS by the last day of the calendar month following the month of assessment.

2. The clinical data set shall be reported to the MHCADSD IS by the last day of the calendar month following the month of assessment.

3. The outcome data set shall be reported to the MHCADSD IS by the last day of the second calendar month following the month of assessment.

C. Case-rate Validation – The data elements necessary to validate a case-rate benefit request are found in Attachment A. Providers shall ensure the posting of all elements to the MHCADSD IS in accordance with the timelines outlined in "Data Dictionary Summary of Attributes" (Attachment A).

D. Carve-outs – The complete set of data elements for all persons being served in carve-out programs shall be posted within two business days of the completion of intake and initial evaluation as defined in Washington Administrative Codes (WACs). Attributes under investigation can be coded as Unknown.

E. All service data detail shall be posted no later than 30 calendar days after the date of service. Service data received after 30th calendar day shall be subject to data timeliness actions.

F. Data elements with a data collection frequency of On Event, Concurrent Review, or On Discharge shall be posted no later than 15 calendar days after the date of change, date of review, or date of discharge. These data elements received after the 15th calendar day shall not be subjected to data timeliness actions.

G. Data Elements with a frequency of On Hire and On Departure shall be posted within 30 days of the date of hire or departure.

1. On Hire – Report on most recent date of hire for staff.

2. On Departure – Report date the staff person leaves employment.

H. Discharge – Providers shall report all required data elements at discharge according to "Data Dictionary Provider Transactions" (Attachment B).

1. For case-rate benefits, discharge is the point at which a client's authorization expires or is terminated. For carve-outs, it is the date a provider determines it shall provide no further services to the client.

2. For a client exited from services prior to the expiration of an authorized benefit or carve-out, providers shall report complete discharge data at the time of exit.

I. Where data is required both as part of discharge of a current authorized benefit and as part of the assessment data requirements of a new case-rate benefit, data submitted as assessment data shall meet the discharge data requirements as well.

J. Inpatient authorizations, extensions, and discharges – The complete set of required data elements for all persons authorized to an inpatient facility shall be posted within two calendar days of the authorization or extension. Discharge data shall be posted within two calendar days of receiving it from the hospital.

K. Investigations, detentions, and legal data under the Involuntary Treatment Act (ITA) – The complete set of required data elements under the ITA shall be posted within two calendar days of the event.

3.1.8 Data Completeness

A. Providers shall report all required elements on all clients as described in "Data Dictionary Summary of Attributes" (Attachment A).

B. No more than one percent of any required attributes as calculated for an individual case-rate benefit or carve-out may be missing from any provider data stored in the MHCADSD IS.

C. Attributes coded as unknown shall not be considered as meeting the requirements for data quality unless otherwise indicated in "Data Dictionary Summary of Attributes" (Attachment A).

D. When an attribute is coded as unknown, providers shall document the justification for the unknown code and update attributes as soon as information becomes available.

1. When a provider has reported the unknown code for more than five percent of any single required attribute in any case-rate benefit or carve-out, the provider may be required to identify the causes of this coding pattern and, where appropriate, develop a plan to obtain the required data.

2. The five percent limitation does not apply to HOST outreach or case-management clients except that as data subsequently becomes known, the provider shall update the attributes.

3.1.9 Data Accuracy

A. The data provider is responsible for ensuring the accuracy of the data submitted and stored in the MHCADSD IS and for resolving any contradictions between the data recorded on the MHCADSD IS and the data recorded in provider records. Providers shall report any necessary corrections.

B. At a minimum, 95 percent of the provider's submission of data for each element stored on the MHCADSD IS shall accurately reflect the contents of provider records.

C. Providers shall maintain written data collection procedures that identify the documents, persons, and specific protocols used to ensure the accurate and timely collection and reporting of data. Providers shall construct these procedures so that a review team may reasonably use them to determine the accuracy of any data elements.

D. Providers shall review and certify the accuracy of reports generated by the MHCADSD IS. Where the provider cannot certify the accuracy of the report, the provider shall immediately report all necessary data to correct the information in the MHCADSD IS so that it does accurately describe the provider's clients, staff, and services.

3.1.10 Unduplication of Client Records

A. MHCADSD IS and providers shall ensure that recipients of mental health services are uniquely identified for purposes of tracking and maintaining service and demographic information attached to that individual.

B. MHCADSD IS shall assign a unique identifier to each person in the mental health system. Providers shall ensure client-related data is always entered under the correct King County Person ID code.

C. Providers shall query the MHCADSD IS to establish whether a client is already known to the mental health system. Providers shall identify and resolve any client duplication issues.

When a provider finds a record on King County that appears to refer to a person who has requested services:

1. The provider shall confirm or eliminate the possible duplication by comparing the identifying elements in the MHCADSD IS master records to the provider collected data; and

2. If the client has been assigned a King County ID and one or more identifying elements stored in the MHCADSD IS Person Record differ from those collected by the provider, the provider shall investigate and determine the correct value(s) prior to reporting any data.

D. When clients are enrolled in more than one RSN, the state system shall produce a Multiple Enrollment Report.

Providers shall respond to this report and resolve the duplication and any out-of-county enrollments within 30 days of notification.

3.1.11 Online Information

A. Providers shall access the King County online Client Lookup System (CLS) or Extended Client Lookup System (ECLS) to query client clinical information, mental health care provider information, and client status prior to providing services to any new client.

The provider shall use the online systems to:

1. Identify all components of the public mental health system involved in the client's care for persons entering service; and

2. Establish whether a client is already known to the MHCADSD IS in order to unduplicate records.

B. Access to and handling of online confidential client information is explained in Section XIII, Security of Information Systems and Client Records.

C. Online access also allows data providers to access clinical, financial, contractual, and data quality reports posted by MHCADSD IS staff.

D. Provider technical reference, assistance, and detailed information on data reporting requirements, specific transaction formats and steps, valid codes, specific programs and algorithms, and other technical information are also available online. (See "Provider Technical Reference" available online.)

3.1.12 Information System Revisions

When a revision is made to this manual that includes new or modified attributes, providers are required to update the MHCADSD IS with the changes at the time of intake or the regularly scheduled concurrent review.

3.1.13 Data Products

A. MHCADSD IS staff, administrators, and other authorized users may create data products derived from the data stored on the MHCADSD IS. All products identified as derived in whole or in part from the MHCADSD IS shall comply with the data policies described in this manual.

B. Any person or agency who wishes to use MHCADSD IS data for any product or purpose shall abide by the requirements for permission for such use as stated in this manual. Permission may be granted by the RSN Evaluation and Research Committee (see Section XIII: Security of Information Systems Data and Client Records).

C. The RSN prohibits the release of information that identifies a client to unauthorized persons (see Section XIII: Security of Information Systems Data and Client Records).

D. Every RSN data product including reports, data sets, or data references, derived in whole or in part from data stored on the MHCADSD IS shall include, at a minimum, an accurate description of the following information:

1. Data Sources – All data presentations shall accurately and completely identify the source of each of the data sets used to derive the final IS product;

2. Run Date – All data presentations shall include the accurate time and calendar date of the report run or data extract. When the user's source data set is itself an aggregation of MHCADSD IS data, the presentation shall include the complete and accurate name, date, and time of the run of the aggregated data source;

3. Data Report Description – When the MHCADSD IS data set or report product is not simply a count of all instances of a data element value, the product shall include:

    a. A complete and accurate statement of the algorithms used to derive each value in the MHCADSD IS product;

    b. The assumptions made in developing each algorithm; and

    c. The impact these assumptions have on the uses of the MHCADSD IS product;

4. In cases where the complete definition or algorithm is too lengthy to include as an integral part of the MHCADSD IS product, a summary shall be included and the complete definition or algorithm made available upon request to any person intending to use the MHCADSD IS product; and

5. The algorithm is the set of instructions used to manipulate the original data set to create the MHCADSD IS product.

E. Reports or data sets produced by the KCMHP on a regular basis and derived in whole or in part from data stored on the MHCADSD IS shall be described in the "Decision Support System" document and directory of "Decision Support Tables" available online.

F. The full source-code for the reports shall be available through the MHCADSD IS upon request. The description shall include:

1. Report or data set title;

2. Frequency of production;

3. General purpose of the report or data set;

4. Full description of report or data set including a general statement of the logic;

5. Name of the program that creates the report or data set;

6. Name of the file produced by the program;

7. Brief operating instructions;

8. Required entities and attributes used; and

9. Text of the central algorithm(s) in the programming language (usually Standard Query Language) used to create the report or data set.

3.2 Procedure: Information Systems Business Rules

3.2.1 Data Tests

All outpatient authorizations requests have a data status. The data status is coded as follows:

ID	Insufficient Data for Payment
PY	Payment Data Set Complete
VL	Validation of Clinical Data Set Complete
OC	Outcome Data Set Complete

A. Data tests are required for all outpatient authorizations and are based on the last case-rate and benefit codes assigned and posted in master event tables.

B. All non-canceled outpatient authorizations are tested for data status and updated each day.

C. Every required element shall be present in the MHCADSD IS tables. Unknowns and nulls are not accepted.

1. Required elements are listed in the "Data Dictionary Summary of Attributes" (Attachment A).

2. Required valid codes are listed in the "Data Dictionary Provider Transactions" (Attachment B).

D. MHCADSD IS is responsible for ensuring that data are posted to the master event tables no later than 7 p.m. on the day following the day of the provider data submission.

E. Where the data timeline is the last day of the calendar month, the posting date time stamp shall be at or before midnight of the last day of the calendar month.

F. Authorizations must have a PY, VL, or OC data status to be paid.

G. The date of posting in the master event table is the date used to determine data status compliance. Data status compliance is met when the record reported by the providers has a posting date no more than 30 days prior to the start date of the benefit and is no later than the last day of the second calendar month of the benefit.

1. Validation of Clinical Data Test: On the first of each month, authorizations that have an ID or PY data status and have a clinical data cutoff date prior to the first of the month are canceled.

2. Outcomes Data Test: For each month past the outcome data cutoff date, a stop payment status shall be set for that month where outcomes data is not complete.

H. The provider is notified each time the data status changes.

3.2.2 Case-rate Validation

Case-rate validation evaluates the data submitted for the specific outpatient benefit case rate requested against the case-rate criteria for that benefit and determines if the request meets the criteria.

A. Case-rate validation is based on data in the MHCADSD IS tables and occurs on a daily basis for all outpatient authorizations.

B. All outpatient authorizations have a Medical Necessity (MN) validation status, null through 3b.

C. Any change in the MHCADSD IS clinical data or requested case rate requires a new MN validation until the clinical data cut-off date.

D. Every change in the MN validation is reported to providers.

E. On the first of each month, requests with a MN validation of null or less than the requested case rate with a clinical data cut-off date prior to the first of the month shall be canceled.

F. A client receiving a specific outpatient benefit shall meet all of the criteria for that benefit.

G. A client meeting the requirements of a requested outpatient benefit shall always be validated to the requested benefit.

H. A monthly report shall be generated for all MN-validated clients who, after the second calendar month, show a data update that no longer meets MN criteria for their authorized benefit.

I. Residential and carve-out benefits are not MN-validated.

3.2.3 Authorization Status Codes

At any one time, an outpatient authorization or carve-out request shall have one of the following status codes:

UA	Unauthorized • Authorization has been received, but coverage not yet evaluated.
AA	Approved • Authorization is approved. • It may still be subject to review by KCMHP.
CX	Canceled • Authorization is canceled.
PN	Pending Manual Review • Authorization is pending. • Pended authorizations are not paid until they are approved. • When they are approved, payment is retroactive.
TM	Terminated • Authorization has been terminated.
WL	Waitlisted • Authorization Waitlisted (for non-Medicaid only)

3.2.4 Non-Medicaid Resource Test

Every submitted outpatient authorization request shall be tested against the non-Medicaid criteria and all non-Medicaid benefits shall be tested against the provider's available non-Medicaid quarterly allocation dollars.

A. All outpatient authorization requests are initially assigned a status of Unauthorized (UA).

B. Until the payment data status has been met (PY), all outpatient authorization requests shall remain at status UA and shall not be tested for coverage.

C. An outpatient authorization request that does not meet non-Medicaid criteria requirements is assigned a KCMHP coverage code (see "Determining Coverage" 3.2.8 in this document) and is not eligible for an authorization.

D. All non-Medicaid outpatient authorization requests that meet the non-Medicaid criteria shall be placed on the waitlist. Requests put on the waitlist shall have a condition code which indicates the condition under the non-Medicaid criteria for which the client qualified.

E. Condition status is calculated based on the data with the earliest event date following the reported assessment date. Condition status code is updated on a daily basis, based on changes to the data in the MHCADSD IS.

F. Where there are sufficient dollars left in the provider's allocation to cover the projected cost of the outpatient authorization request, the request shall be taken off the waitlist and given the status of Authorization Approved (AA), and the benefit shall follow standard authorization processes.

G. When there are insufficient dollars left in the provider's quarterly allocation, no more non-Medicaid outpatient requests shall be authorized from the waitlist.

3.2.5 Cancellation of Waitlist Outpatient Authorization Requests

A. Where a waitlisted outpatient authorization request does not meet data or MN status at the close of the second calendar month, the authorization request shall be canceled.

B. Where a WL status outpatient authorization request is canceled as noted above, the assessment date for a new authorization request must fall after the termination date of the WL status request.

3.2.6 Non-Medicaid Waitlist Update

A. Non-Medicaid benefit requests that meet the non-Medicaid criteria shall be put on the waitlist in the order in which they were received. Requests put on the waitlist shall have an authorization status code WL.

B. Based on the provider's available quarterly non-Medicaid dollars allotment, a number of benefit requests on the waitlist shall be authorized and the authorization status shall change from WL to PN, if a manual review is required, or AA if a review is not necessary. Benefits shall be authorized in the order of waitlist post date.

C. On a daily basis, condition code shall be recalculated for all authorizations on the waitlist, based on information in the MHCADSD IS. Authorizations that no longer meet the non-Medicaid condition to be on the waitlist shall be removed.

D. The start date of an authorized WL status outpatient authorization is the date the authorization request is removed from the waitlist, unless today is less than the original start date (Next Benefit).

3.2.7 Determination of Residency

A. The CSO Code and County Code as reported by the provider determines King County residency.

B. When a client becomes a non-King County resident, the benefit shall be terminated effective the event date of the change as reported by the provider.

3.2.8 Determining Coverage

A. When a provider has submitted an outpatient authorization request for a client meeting the payment data status test, the system shall test the request for coverage (see table below) based on the data submitted by the provider. The provider submitted coverage data will be compared with coverage data obtained from the DSHS ProviderOne system. When a discrepancy is detected the outpatient authorization request will remain in an unauthorized (UA) state until the discrepancy is cleared.

B. Medicaid coverage is always effective for a complete month, irrespective of the event date reported by the provider.

Where a client loses Medicaid coverage within a month, the new coverage status shall be calculated and applied to the month following the Medicaid covered month.

C. Eligibility for KCMHP services by MHCADSD IS coverage type is detailed in the following table:

Summary of Coverage Type and Eligibility for Benefits

Coverage Type		**Eligibility for Benefits if Criteria are Met**
F19	King County resident with eligible Medicaid program/match combination	Eligible for KCMHP outpatient benefits
PHP	King County resident without eligible Medicaid program/match combination: • “Non-Medicaid”, and • <200% poverty adult or older adult; or • <300% poverty child	Eligible for KCMHP outpatient benefits, when funding is available

Coverage Type		Eligibility for Benefits if Criteria are Met
OCM	Out-of-County—Medicaid	Not eligible for KCMHP benefits
OCU	Out-of-County—Non-Medicaid	Not eligible for KCMHP benefits
RSN	King County resident without eligible Medicaid program/match combination: • "Non-Medicaid" and • >/=200% poverty adult or older adult; or • >/=300% poverty child	Eligible for some carve-outs only

D. Non-Medicaid and Medicaid covered clients are eligible for identical outpatient benefits.

E. The system shall recalculate coverage when a provider submits changes to any data elements that determine coverage (Medicaid record, income record, county code).

F. Coverage changes reported by a provider shall be applied retroactively to terminate a benefit on the last day of valid coverage except that where a provider fails to report a series of coverage changes within reporting timelines, adjustments shall be based on the date of the last coverage change.

G. Automated review of coverage for purposes of benefit termination shall not be processed until the validation data status timeline is past.

3.2.9 Provider Outpatient Authorization Requests

The MHCADSD IS business rules for each of the provider initiated outpatient authorization requests are detailed as follows:

A. For all outpatient authorization requests:

1. All authorization requests from providers are processed within 24 hours of posting unless they require KCMHP approval;

2. Authorization requests that fail to meet the rules as noted shall be rejected;

3. The assessment date must never be later than the posting date;

4. A request for interim case-rate change, catastrophic case-rate change, provider change, or a next benefit shall refer to a valid authorization that has not been canceled or terminated;

5. If the authorization is pending a manual review, the request shall be rejected;

6. If the client has an outstanding outpatient authorization or provider change request pending, the request shall be rejected;

7. Providers shall receive daily reports on all actions taken; and

8. When an authorization request cannot be processed the provider shall be notified via daily error reports.

B. Initial Authorization Requests – For a new client:

1. The posting date must be on or before the assessment cut-off date. The assessment cutoff date is the end of the 2nd calendar month from the authorization's assessment date;

2. If the authorization request requires a manual review, the new authorization shall be created with a pending (PN) status; and

3. If a manual review is not required, the authorization is created with an AA status.

C. Interim Case-Rate Change Request – For requests to change the case rate for an existing outpatient authorization:

1. Any interim case-rate change request can be made only once a day;

2. The posting date must be on or before the authorization change cutoff date. The authorization change cut-off date is the end of the 2nd calendar month from the authorization start date;

3. The assessment date is not used to set the start date for this type of request;

4. The authorization number is not changed by this action;

5. A change to a case-rate request has no effect on the data attached to the outpatient authorization request;

6. The case rate requested by the provider is assigned in the MHCADSD IS without regard to case-rate criteria: validation shall occur later when the authorization is retested for data timelines and case-rate criteria;

7. The case-rate re-determination is retroactive to the start date of the authorization and an adjustment shall be made to any payments; and

8. If KCMHP has already approved the authorization (a manual review was approved), the request shall be rejected.

D. Catastrophic Case-Rate Change Request – For requests to change the case rate due to a catastrophic and permanent change in the client:

1. The assessment date of the request shall be after the authorization cut-off date and on or before the expiration date of the existing authorization;

2. The posting date of the request for a case-rate change shall be on or before the assessment cut-off date of the catastrophic case-rate change request;

3. All catastrophic case-rate change requests require a manual review;

4. Upon approval by KCMHP, the existing outpatient authorization is terminated as of the day before the assessment date of the request; and

5. A new pending outpatient authorization is created with a start date equal to the assessment date of the new request and with the new case rate.

E. Provider Change Request – For provider change initiated by clients:

1. The assessment date of the request shall be after the start date of the existing outpatient authorization and on or before the expiration date of the existing authorization;

2. The posting date of the provider change request shall be on or before the assessment cut-off date of the provider change request;

3. The existing authorization is terminated as of the day before the assessment date of the request;

4. A new outpatient authorization is created with a start date equal to the assessment date of the request; the case rate is set to the case rate in the request;

5. The provider change request requires manual review, if either of the following conditions are true:

   a. The client has already changed providers in the last 12 months; or

   b. The new authorization requires manual review;

6. If the provider change request requires manual review, the following applies:

   a. The new authorization request is created with a pending status; and

   b. The existing authorization is not terminated until the provider change is approved; and

7. If the provider change does not require manual review, the new authorization is created with an AA status.

F. Continued Stay Request – For provider request to renew an existing authorization benefit:

1. The assessment date of the request shall be within the last 30 days of the current authorization;

2. The posting date of the continuation request must be on or before the assessment cut-off date of the next authorization request;

3. The start date of the new authorization shall be set to the day following the expiration date of the current authorization;

4. The provider may request a case rate different from the case-rate of the existing authorization; and

5. The authorization may require a manual review. If so, the status of the authorization shall be set to PN.

G. Provider Request for Cancellation – For provider requests to cancel an existing authorization request due to a submission error:

1. The posting date shall be on or before the authorization change cut-off date;

2. The existing authorization request shall not already have a cancellation status; and

3. LTR authorizations can only be canceled by KCMHP.

H. Provider Request for Termination

1. The posting date shall be no more than 60 days after the expiration date of the existing authorization.

2. The existing authorization shall not already be canceled or terminated.

3. The authorization does not have a pending manual review.

3.2.10 KCMHP Outpatient Authorization Functions

A. KCMHP shall review flagged cases

1. KCMHP may approve the requested authorization, change the case rate, pend the review, or cancel the authorization request.

2. KCMHP may approve an outpatient authorization request at any time up to the review cut-off date. The review cut-off date is 14 days past the end of the second calendar month from the authorization start date. A review cannot be started after the review cut-off date.

3. Outpatient authorization requests requiring KCMHP review that are not approved by the review cut-off date are automatically canceled.

4. KCMHP can only approve outpatient authorization requests that have met clinical data validation. KCMHP cannot authorize an outpatient authorization request that is not supported by MN.

5. KCMHP may cancel an outpatient authorization request as a result of failure of the provider to meet benefit response timelines (i.e., the provider fails to submit a complete request within the timelines required).

6. The result of a KCMHP review is reported to the provider.

B. A retroactive authorization allows authorized users to create an authorization record without an existing authorization request, provided that the start date of the authorization is within 365 days from the authorization request. (See Section IV, Financial Management under "Exceptions to Policy".)

1. A retroactive authorization is not based on a provider-submitted authorization request.

2. The start date cannot be in the future.

3. The expiration date shall be equal to or greater than the start date and cannot be more than 364 days after the start date.

4. Only payment data requirements apply.

5. There are no MN validation requirements.

6. A retroactive authorization request is not subject to the waitlist.

7. The case-rate code is based on demographic data in the system. It cannot be overridden.

3.2.11 Authorization Response Record

A. Providers shall receive notification of every action taken on each authorization request submitted. (See the Authorization Response Transaction in the "Provider Technical Reference," available online, for format.)

B. An authorization response record is created upon:

1. Changes made to the submitted clinical or demographic data, authorization duration, case rate, provider and/or status; and

2. System validation of data or MN.

3.3 Information System Business Rules:

3.3.1 Service Periods

The service period is the duration of the benefit, from start date to expiration date.

A. A client is assumed to be receiving services under a case-rate benefit carve-out program or inpatient services during the calendar dates on or following the start date through to the expiration date recorded in the MHCADSD IS.

B. The expiration date for a benefit is 364 days from the start date (a 365-day benefit).

C. The expiration date may be null, indicating the benefit is open.

1. A carve-out or inpatient services authorization shall have a null expiration date until the provider submits a notice of exit.

2. A residential benefit and a case-rate benefit shall never have a null expiration date.

D. The default expiration date may be overridden by authorized KCMHP staff when creating a retroactive authorization.

E. A supervised living benefit shall have an associated case-rate benefit; the supervised living expiration date defaults to the expiration date of the associated case-rate benefit.

3.3.2 Case-Rate Benefit Case-Rate Code Calculation

A case-rate code is assigned to every authorized benefit to determine the benefit payment amount. The actual case-rate amount paid depends on the case-rate code, the benefit, and the payment month. (See Section IV, Financial Management, “Case Rates,” Attachment A.)

A. Case-rate code is based on data stored in the information system.

B. The case-rate code may change from month to month and the change is applicable for an entire month in which the change appears.

C. The case-rate code is determined by four factors: 1) provider, 2) cultural differential status, 3) the age of the client on the assessment date, and 4) language differential status.

1. “Provider” is the contractor holding the benefit authorization.

2. “Cultural differential status” is calculated from the combined values of the client’s cultural differential population group (see Definitions), the case-rate benefit, and, for ethnic minorities or sexual minorities, a service that qualifies the benefit for the cultural differential case rate.

A service that qualifies the benefit for the cultural differential case rate is one that combines the following two factors:

a. The CPT code is on the list of accepted assessment or evaluation codes, and

b. The Staff Qualifications are coded as African American, Asian/Pacific Islander, Hispanic, or Native American Ethnic Minority MH specialists (03 through 06), Sexual Minority MH Specialist (08), or Other Ethnic Minority MH Specialist (09).

3. For deaf or hard-of-hearing clients, the impairment codes that qualify for cultural differential status are Deaf (32) or Hard-of-hearing (33).

4. For non-facility-based medically compromised homebound clients, the impairment kind code that qualifies for cultural differential status is Medically Compromised (43), and the residential arrangement codes that qualify are Permanent Housing-unassisted (01), Permanent Housing-assisted (02), Temporary Housing-unassisted (03), Temporary Housing-assisted (04), Temporary Housing-dependent (05), Transitional Housing (06), Adult Family Home (22), Foster Care for children (26), and Homeless (82).

5. "Age" of the client is calculated from the provider-reported birth date of the client.

6. If the client is a child, "language differential status" is calculated if an interpreter is needed. If the client is an adult or older adult, the "language differential status" requires both that an interpreter is needed and that the client's language is not English.

D. Where elements used to calculate case-rate code are coded as unknown, the case-rate code defaults to the non-special population adult case-rate code, with no language differential.

E. Submission of new demographic information by the provider can trigger a recalculation of case-rate code at any time up to the authorization change cut-off date.

F. Submission of a service that qualifies the benefit for the cultural differential case rate during the first three calendar months of the benefit shall trigger a retroactive calculation of the case-rate code. If qualifying services for cultural differential is received after the first three months the case rate shall start the month following the date of submission.

3.3.3 Management of Non-Medicaid Dollars

A. The quarterly allotment of non-Medicaid dollars shall be updated on the 15th of the month prior to the calendar quarter (see Section VI Outpatient Services Level of Care).

B. The allotment shall take into account the expenditures for non-Medicaid benefits year to date, to account for any benefits authorized through the exception procedure or due to spenddown status.

C. For benefits where the client has lost Medicaid coverage, the client funding status shall be checked to see if any individuals who were authorized as non-Medicaid have been converted to Medicaid during the past calendar month. If so, the amount of the remaining future payments for their authorized benefit shall be reduced from the non-Medicaid encumbrance.

D. The system allotment shall be structured to provide as consistent a level of new benefits authorization throughout the year as is practicable.

E. As each non-Medicaid benefit is authorized, the amount of the remaining quarterly allotment shall be reduced and future payments will be encumbered. When the quarterly allotment is fully converted into non-Medicaid benefit authorizations, no more benefits shall be authorized during the calendar quarter, except for those authorized through the exception process.

If there are funds left in the quarterly allotment, and the dollar amount is not sufficient to authorize a whole new benefit, the dollars shall be rolled forward into the amount available for the remaining quarters of the year.

3.4 Responsibilities

3.4.1 King County Mental Health, Chemical Abuse and Dependency Services Division (KCMHCADSD)

A. KCMHCADSD is responsible for the design, management, and operation of the MHCADSD IS.

B. KCMHCADSD is responsible for ensuring and overseeing the security of the MHCADSD IS.

C. KCMHCADSD shall provide reasonable technical assistance and support to KCMHP providers to enable providers to establish and maintain technical interface with the MHCADSD IS.

D. KCMHCADSD shall produce data reports and tables to support the clinical and administrative functions of the RSN/MHP.

3.4.2 Providers

KCMHP providers and specialized services agencies required to input or access information on the MHCADSD IS shall develop, implement, and maintain information systems structures and personnel to support the policies, procedures, and requirements detailed in this manual.

4.0 LIST OF ATTACHMENTS:

4.1 Attachment A: Data Dictionary Summary of Attributes

4.2 Attachment B: Data Dictionary Provider Transaction

4.3 Attachment C: HIPAA Trading Partner Agreement

4.4 Attachment D: Trading Partner Agreement 837P

4.5 Attachment E: Service Encounter Reporting Instructions

5.0 REFERENCES:

Federal Law, Regulations, and Policy including any successor, amended, or replacement laws, regulations, or policies

- 42 Code of Federal Regulations (CFR) Part 2 Confidentiality of Alcohol and Drug Abuse Patient Records
- 42 CFR Part 438 Managed Care
- 42 CFR Parts 400, 430, 431, 434, 435, 440
- 45 CFR Part 142 Security and Electronic Signature Standards
- 45 CFR Parts 160 and 164 Standards for Privacy of Individually Identifiable Health Information
- 45 CFR Part 162 Health Insurance Reform: Modifications to Standards for Electronic Transactions and Code Sets

Washington State Law, Regulations, and Policy including any successor, amended, or replacement laws, regulations**,** or policies

- Chapters 388-865, 388-877, 388-877A WAC – Department of Social and Health Services – Mental Health – Community Mental Health and Involuntary Treatment Programs
- Chapter 10.77 Revised Code of Washington (RCW) – Criminal Procedure – Criminally Insane
- Chapter 13.50 RCW – Juvenile Courts and Juvenile Offenders – Keeping and Release of Records by Juvenile Justice or Care
- Chapter 70.02 RCW – Public Health and Safety – Medical Records – Health Care Information Access and Disclosure
- Chapter 71.05 RCW – Mental Illness -- Mental Illness
- Chapter 71.24 RCW – Mental Illness – Community Mental Health Services Act
- Chapter 71.34 RCW – Mental Illness – Mental Health Services for Minors

Summary Table of Attributes

Summary Table of Transactions and Attributes

Key to abbreviations of Levels of Care:

OP = Outpatient
RS = Residential
IP = Inpatient
CR = Crisis

Transaction	Attribute	Required for				Reporting Requirements
		OP+	RS	IP	CR*	
Activity Evaluation		X	X			Initial Assessment, On change
	Reporting Unit ID					
	Case ID					
	Event Date					
	Employment Status					
	Education Status					
	Other Activity Code					
	Grade Level					
	King County ID					
Authorization Request		X	X	X	X	Initial Assessment, On change
	Reporting Unit ID					
	Case ID					
	Date of Assessment					
	Benefit/Program Requested					
	Benefit Change Code					
	Request Date					
	Authorization Number					
	Team Service Flag (child)					
	King County ID					
Batch Footer						With every batch
	Batch ID					
	Date of Submittal					
	Source Organization ID					
	Record Count					
Batch Header						With every batch
	Batch ID					
	Date of Submittal					
	Source Organization ID					

Transaction	Attribute	Required for				Reporting Requirements
		OP+	RS	IP	CR*	
Case Manager Contact Information		X				On Assignment, On change
	Reporting Unit ID					
	Case Manager ID					
	Primary Case Manager Phone					
	Primary Case Manager Comment					
	Secondary Case Manager Phone					
	Secondary Case Manager Comment					
	Case Manager Password					
Case Manager Link		X				Initial Assessment, On change
	Reporting Unit ID					
	Case ID					
	Case Manager ID					
	Case Manager Reporting Unit ID					
Client Demographics		X	X	X	X	Initial Assessment, On change
	Reporting Unit ID					
	Case ID					
	Event Date					
	Surname					
	Given Names					
	Gender					
	Date of Birth					
	Ethnicity					
	Hispanic Origin					
	Interpreter Required					
	Language Code					
	Sexual Minority Status					
	Military Status					
	Family Military Status					
	Social Security Number					
	King County ID					

Transaction	Attribute	Required for				Reporting Requirements
		OP+	RS	IP	CR*	
Conditions at Assessment		X				Assessment. Required for children outpatient authorization and Non-Medicaid outpatient authorization.
	Reporting Unit ID					
	Client ID					
	Assessment Date					
	Condition Code					
	King County ID					
COD Assessment		X	X			When the individual scores a 2 or higher on either of the first two scales (ID Screen & ED Screen) and a 2 or higher on the third (SD Screen).
	Reporting Unit ID					
	Case ID					
	Event Date					
	Quadrant					
	Authorization Number					
	King County ID					
COD Screening		X	X		X	Initial Assessment Treatment Plan Review – one time only (during 2007) for individuals already enrolled in ongoing outpatient treatment services. Crisis Episode – only if not completed (by any provider) in the previous 12 months
	Reporting Unit ID					
	Case ID					
	Event date					
	IDS Score					
	EDS Score					
	SDS Score					
	Authorization Number					
	King County ID					

Transaction	Attribute	Required for				Reporting Requirements
		OP+	RS	IP	CR*	
CPT Service Detail (since 10/15/03, this required data is submitted in the HIPAA 837 transaction)		X	X		X	On Event
	Reporting Unit ID					
	Case ID					
	Service Transaction ID					
	Event Date					
	CPT Code					
	Service Modifier					
	Minutes of Service					
	Service Location					
	EPSDT Indicator					
	Staff Person Provider ID					
	Staff Person ID					
	Authorization Number					
	King County ID					
	Address Line 1					
	Address Line 2					
	City					
	State					
	Zip					
Crisis Diversion Services					X	For Crisis Diversion Facility Team program (80) only.
	Reporting Unit ID					
	Case ID					
	Authorization Number					
	Diversion Type					
	Primary Presenting Condition					
	Arrival Date Time					
	Exit Date Time					
	Service Level					
	King County ID					
Diagnosis		X	X	X	X	Assessment, On change, On Discharge
	Reporting Unit ID					
	Case ID					
	Diagnosis Code					
	Event Date					
	Diagnosis Axis					
	Axis Subtype					
	Authorization Number					
	King County ID					

Transaction	Attribute	Required for				Reporting Requirements
		OP+	RS	IP	CR*	
Disability		X	X	X	X	Assessment, On change
	Reporting Unit ID					
	Case ID					
	Event Date					
	Impairment Kind					
	Substance Abuse					
	King County ID					
HIPAA Health Care Claims 837 Professional		X	X	X	X	On Event Not accepted for programs 101,103
Income Category		X	X			Initial Assessment, Change
	Reporting Unit ID					
	Case ID					
	Event Date					
	Annual Income					
	Family Size					
	King County ID					
Medicaid Coverage		X	X			Initial Assessment, On change
	Reporting Unit ID					
	Case ID					
	Event Date					
	CSO Identifier					
	Medicare Indicator					
	Private Pay Indicator					
	Third Party Coverage Indicator					
	ProviderOne ID					
	King County ID					
MHRM Summary		X				On trauma screening, every six months after trauma screening, On discharge or grant end, if earlier. For Trauma-informed Care Grant program (109) only.
	Reporting Unit ID					
	Case ID					
	Event Date					
	MHRM Total					
	MHRM Missing					
	King County ID					

Transaction	Attribute	Required for				Reporting Requirements
		OP+	RS	IP	CR*	
Mobile Crisis Team Intervention					X	For Mobile Crisis Team program(76) only
	Reporting Unit ID					
	Case ID					
	Authorization Number					
	Diversion Type					
	Primary Presenting Condition					
	Episode Start Date/Time					
	Episode End Date/Time					
	Homeless Indicator					
	Zip Code					
	King County ID					
Notice of Exit		X	X	X	X	Exit from program
	Reporting Unit ID					
	Case ID					
	Event Date					
	Authorization Number					
	Exit Code					
	Reason for Termination/Cancellation					
	King County ID					
Problem Severity Summary		X				Initial Assessment, Discharge. Required only for COD program (64, 69) and Jail Transition Services programs (55, 56), and MIDD-funded Adult and Older Adult Outpatient Benefits (2X1, 3A1, 3B1). For MIDD-funded tiers that will be continued, submit a transaction for both benefits, but use the same screening.
	Reporting Unit ID					
	Case ID					
	Event Date					
	Dangerous Behavior					
	Socio-legal					
	Negative Social Behavior					
	Self-care					
	Community Living					
	Social Withdrawal					
	Response to Stress					
	Sustained Attention					
	Physical					
	Health Status					
	Depressive Symptoms					
	Anxiety Symptoms					
	Psychotic Symptoms					
	Dissociative Symptoms					
	Cognitive					
	Authorization Number					
	King County ID					

Transaction	Attribute	Required for				Reporting Requirements
		OP+	RS	IP	CR*	
PSS-I Symptoms		X				On trauma screening, every six months after trauma screening, On discharge or grant end, if earlier. For Trauma-Informed Care Grant program (109) only.
	Reporting Unit ID					
	Case ID					
	Event Date					
	Problem List Total					
	Problem List Missing					
	Interference List Total					
	Interference List Missing					
	King County ID					
PSS-I Trauma History		X				On trauma screening, every six months after trauma screening, On discharge or grant end, if earlier. For Trauma-Informed Care Grant program (109) only.
	Reporting Unit ID					
	Case ID					
	Event Date					
	Accident Fire Explosion (01)					
	Natural Disaster (02)					
	Assault by Known Person (03)					
	Assault by Unknown Person (04)					
	Sexual Assault by Known Person (05)					
	Sexual Assault by Unknown Person (06)					
	Combat War Zone (07)					
	Early Sexual Contact (08)					
	Imprisonment (09)					
	Torture (10)					
	Life-threatening Illness (11)					
	Other Trauma (12)					
	Other Trauma Description					
	Worst Trauma					
	Treatment Reason					
	Physical Injury to Self					
	Physical Injury to Other					
	Own Life in Danger					
	Other's Life in Danger					
	Felt Helpless					
	Felt Terrified					
	King County ID					

Transaction	Attribute	Required for				Reporting Requirements
		OP+	RS	IP	CR*	
Program Referral		X		X	X	Initial Assessment, Discharge
	Reporting Unit ID					
	Case ID					
	Authorization Number					
	Event Date					
	Referral Type					
	Program Type					
	Agency / System					
	Linkage Indicator					
	King County ID					
Residential Absence			X			On Occurrence
	Reporting Unit ID					
	Case ID					
	Absence Start Date					
	Absence Last Date					
	Facility Code					
	King County ID					
Residential Arrangement		X	X	X	X	Initial Assessment, On change
	Reporting Unit ID					
	Case ID					
	Start Date					
	Residential Arrangement Code					
	Zip Code					
	County Code					
	King County ID					
Residential Facility			X			Assessment, On change
	Reporting Unit ID					
	Case ID					
	Start Date					
	Exit Date					
	Facility Code					
	King County ID					

Transaction	Attribute	Required for				Reporting Requirements
		OP+	RS	IP	CR*	
Staff Person		X	X		X	On hire, On Discharge
	Reporting Unit ID					
	Staff Person ID					
	Start Date					
	End Date					
	Surname					
	Given Names					
	Gender					
	Language Code					
	King County ID					
Staff Qualifications		X	X		X	On hire, On change
	Reporting Unit ID					
	Staff Person ID					
	Specialty Area					
Substance Use Frequency		X				Intake Assessment: for programs 55, 56, 69, 83, 87 every six months after intake: for programs 83, 87 every 12 months after intake: for programs 55, 56, 69 Discharge: for programs 55, 56, 69, 87
	Reporting Unit ID					
	Case ID					
	Event Date					
	Alcohol					
	Amphetamines					
	Barbiturates					
	Benzodiazepines					
	Cocaine					
	Hallucinogens					
	Heroin					
	Inhalants					
	Major Tranquilizers					
	Marijuana-Cannabis					
	Methamphetamine					
	Other Sedatives or Hypnotics					
	Other Opiates and Synthetics					
	Other					
	Over the Counter					
	Oxy/Hydro Codone					
	PCP					
	Prescribed Opiate Substitute					
	Tobacco Products					
	Authorization Number					
	King County ID					

Transaction	Attribute	Required for				Reporting Requirements
		OP+	RS	IP	CR*	
Vulnerability Assessment Transaction						On referral for shelter or housing. At each 12- month anniversary, if continuing to seek shelter/housing
	Survival Rating					
	Basic Needs					
	Indicated Mortality Risks					
	Medical Risks					
	Organization Orientation					
	Mental Health					
	Substance Use					
	Communication					
	Social Behaviors					
	Homelessness					
	Veteran Status					
	Assessor ID					
	King County ID					

Programs and Required Transactions

Programs 05 (Municipal Mental Health Court) and 06 (KC Regional Mental Health Court)

- Authorization Request
- Client Demographics
- Disability
- Medicaid Coverage
- Notice of Exit
- Program Referral
- Residential Arrangement

Crisis programs 13 and 15 (Children Crisis Outreach and Response System)

- Authorization Request
- Client Demographics
- COD Screening
- Disability
- HIPAA Health Care Claims 837 Professional
- Notice of Exit
- Residential Arrangement
- Program Referral

Program 25 Specialty Employment Program (SEP

- Authorization Request
- HIPAA 837P for service data
- Notice of Exit

Crisis programs 74 (Adult Inpatient Diversion Bed) and 75 (Crisis Respite Program - DESC)

- Authorization Request
- Client Demographics
- Notice of Exit

Note: service data is required for these crisis programs for submission to the state. In lieu of providers having to submit a service record for each day the client is in the program, MHCADSD information system will generate the service records based on the authorization start date and end date submitted by providers.

Program 76 (Mobile Crisis Team)

- Authorization Request
- Client Demographics
- HIPAA 837P for service data
- Mobile Crisis Team Intervention
- Notice of Exit
- Program Referral

Program 79 (Crisis Diversion Interim Services)

- Authorization Request
- Client Demographics
- COD Screening (Complete if not completed by CDF)
- Diagnosis
- Disability
- Notice of Exit
- Program Referral
- Residential Arrangement
- VA Transaction (Complete for Client Care Coordination only)

Program 80 (Crisis Diversion Facility Team)

- Authorization Request
- Client Demographics
- Crisis Diversion
- COD Screening
- Disability
- Notice of Exit
- Program Referral
- Residential Arrangement
- VA Transaction

Program 101 (Housing Voucher) and 103 (Re-entry Case Management)

- Authorization Request
- Client Demographics
- Disability
- Diagnosis
- Notice of Exit
- Program Referral
- Residential Arrangement

Program 105 (Behavioral Treatment at CCAP)
- Authorization Request
- Client Demographics
- Disability
- Diagnosis
- Notice of Exit
- Program Referral
- Residential Arrangement
- HIPAA Health Care Claims 837 Professional (use CPT code 90853)
- Staff Person
- Staff Qualifications

Outpatient programs 107 (MIDD Wraparound)
- Authorization Request
- Client Demographics
- Disability
- HIPAA 837P for service data
- Notice of Exit
- Program Referral
- Residential Arrangement

Outpatient program 109 (Trauma-Informed Care Grant)
- HIPAA 837P for service data
- Notice of Exit

Program 110 Transitional Recover Program Mental Health Professional
- Authorization request
- Client Demographics
- Co-Occurring Disorders Assessment
- Program Referral
- Residential Arrangement

Program 111 (Moral Reconation Therapy-Domestic Violence)
- Authorization request
- Client Demographics
- Diagnosis
- Disability
- Notice of exit
- Problem Severity Summary
- Program referral
- Residential Arrangement
- Services

Program 112 (Assessment Only (OPB): Client did not meet medical necessity for outpatient benefit)
- Authorization Request
- Medicaid Coverage
- Request for Services (service)
- Intake Service (service)

Program 113 (Transition Support Program - Discharge Planning & Support)

- Authorization request
- Client Demographics
- Diagnosis
- Disability
- Notice of Exit
- Residential Arrangement
- Services

Outpatient programs 151, 153, and 154 (Criminal Justice Liaison Programs)

- Activity Evaluation
- Authorization Request
- Client Demographics
- Diagnosis
- HIPPA 837P for service data
- Notice of Exit
- Program Referral
- Residential Arrangement

Table of Contents

Transaction: Activity Evaluation 3

Transaction: Authorization Request 10

Transaction: Batch Footer 20

Transaction: Batch Header 21

Transaction: Case Manager Contact Information 22

Transaction: Case Manager Link 26

Transaction: Children's Functional Assessment Rating Scale 28

Transaction: Client Demographics 32

Transaction: Conditions at Assessment 48

Transaction: Co-Occurring Disorders Assessment 62

Transaction: Co-Occurring Disorders Screening 64

Transaction: CPT Service Detail 68

Transaction: Crisis Diversion Services 87

Transaction: Diagnosis 93

Transaction: Disability 126

Transaction: HIPAA Health Care Claims 837 Professional 130

Transaction: Income Category 131

Transaction: Medicaid Coverage 134

Transaction: MHRM Summary 140

Transaction: Mobile Crisis Team Intervention 144

Transaction: Notice of Exit 151

Transaction: Problem Severity Summary 163

Transaction: PSS-I Symptoms 169

Transaction: PSS-I Trauma History 175

Transaction: Program Referral 183

Transaction: Residential Absence 192

Transaction: Residential Arrangement 197

Transaction: Residential Facility 205

Transaction: Staff Person 209

Transaction: Staff Qualifications 217

Transaction: Substance Use Frequency 223

Transaction: Vulnerability Assessment Transaction 228

Transaction: UNIVERSAL ATTRIBUTES AND DEFINITIONS 237

Transaction: Activity Evaluation

Definition:
An outcome measure describing the client's employment, education, and other activities.

Required for:
Outpatient, Residential

Frequency:
Initial assessment
On change

Procedure:
- A new set of Employment Status codes are effective October 1, 2011. Code sets for all other attributes are unchanged.
- Effective October 1, 2011, only current Employment Status codes will be accepted.
- Providers must update the Employment Status for all employment age adults (18-64) with open Outpatient or Residential authorizations no later than December 31, 2011.
- Effective October 1, 2011, new outpatient benefit or supportive housing authorization requests must have currently active employment codes in order to meet data requirements.

Transaction ID: 040.04

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Event Date	Text (YYYYMMDD)	8	
Employment Status	Text	2	Y
Education Status	Text	2	Y
Other Activities	Text	2	Y
Grade Level	Text	2	Y
King County ID	Text (number)		

Attribute: *Event Date*

Definition:
On assessment, the event date is the date of assessment as reported in the authorization request.

On change, the event date is the date of the actual change, or where not known exactly, the best available estimate.

Procedure:
- Whenever a change occurs in one of the four activity areas (employment, education, other activities, or grade level), submit a transaction with the event date of the changed attribute, the new code for the changed attribute, and the previously reported codes for the other attributes. All four attributes will be stored in a single record with the single event date, and only the attribute(s) with the new code(s) will be considered to have changed.
- If the change is due to the new employment status code, the event date is the date when the client's employment status using the new set of codes is re-evaluated.

Attribute: *Employment Status*

Transaction:
Activity Evaluation

Definition:
A code that describes the client's status with respect to paid work.

Procedure:
- Where a client meets more than one definition below, report the lowest code that applies.
- On assessment, report the date of the assessment.
- On change, report the actual date of the change. Where unknown, report the best estimate and document in the file.
- If the change is due to the new employment status code, the event date is the date when the client's employment status using the new set of codes is re-evaluated.
- To meet the Employment data status requirement for authorizations with a Start Date that is on or after November 1, 2011, there must be an activity record for the client from the provider that was posted to the ep_activity table on or after October 1, 2011. This updated data is required because all Employment Status codes were replaced with a new set of codes on October 1, 2011.
- This is used for State and MHCADSD outcome measures and for the MHCADSD "Employment Increase" Recovery Incentive measure.

Required Documentation:
Provider records shall document all employment including the source of information used to code this attribute.

Examples:
1. During an assessment, the client reports she holds two part-time jobs, one for 25 hours a week as a nursing assistant and the second for 15 hours a week as a teacher's aide. Report the client as employed competitively full-time (Code 21), since the total hours of employment exceed 35 hours.
2. A client attends college and has a 15 hour a week work-study job. Report as employed competitively less than 20 hours a week (Code 23).
3. An unemployed client is referred to a supported employment program and begins receiving job placement services. Report as not employed but actively looking for work (Code 25). Two months later, she obtains a 20-hour a week competitive job and continues to receive supported employment services. Report as employed competitively 20-34 hours a week (Code 22).
4. An unemployed client begins receiving DVR services and begins receiving job placement services. Report as not employed but actively looking for work (Code 25). Two months later, he obtains a 20 hour a week job and continues to receive employment supports through DVR. Report as employed competitively 20-34 hours a week (Code 22).
5. A client works 20 hours a week in a three-month transitional employment job associated with a clubhouse. Report as employed in a non-competitive job (Code 24).
6. A client accompanies her elderly neighbor to the store each week to help with shopping, but is not interested in finding paid employment. Report as not in labor force (Code 26).
7. A client volunteers weekly at a local food bank. Report as not in labor force (Code 26).

Type: Text (2)

Valid Codes	Definition
	Employment
21	Employed Competitively Full-time: 35 hours or more paid employment per week
22	Employed Competitively Part-time: 20-34 hours paid employment per week
23	Employed Competitively Part-time: Less than 20 hours paid employment per week
24	Employed in a non-competitive job (1 or more hours per week). Position is considered non-competitive if it meets any one or more of the following criteria: • Position is in a "sheltered" or protected setting in which the typical performance expectations of mainstream jobs do not apply. • Applications for position are deemed eligible based solely upon an individual's diagnosis of a mental illness or of a developmental or other disability, rather than on specific job qualifications related to the duties and responsibilities of the position. • Position is limited to specific group/type of individuals (i.e., consumers receiving services at a particular agency) and not available to anyone who meets identified job qualifications. • Co-workers/peers are primarily mental health consumers or individuals with a common disability. • Salary is less than minimum wage
25	Not employed: Actively looking for work may consist of any of the following activities: • Participating in a supported employment, or certified clubhouse employment, program • Contacting: o An employer directly or having a job interview o A public or private employment agency o Friends or relatives o A school or university employment center • Sending out resumes or filling out applications • Placing or answering advertisement • Checking union or professional registers • Some other means of active job search
26	Not in Labor Force: Retired, Volunteer, Homemaker, Student, Disabled, etc. Persons who are neither employed nor actively looking for employment.

Attribute: Education Status

Transaction:
Activity Evaluation

Definition:
A code that describes the client's involvement in formal learning activities.

Procedure:
- On assessment, report the date of the assessment.
- On change, report the actual date of the change. Where unknown, report the best estimate and document in the file.
- This is a state and MHCADSD outcome measure.

Required Documentation:
Provider records shall document education status including the source of information used to code this attribute.

Examples:
1. A youth attends high school 15 hours a week to complete classes required to graduate. He also does volunteer work at a nursery because he wants to eventually work for a landscaping firm. Submit Code 41.
2. A child is taught at home by his mother under a formal plan for home schooling. Submit Code 21.
3. A youth has graduated from high school and attends vo-tech school 15 hours a week. Submit Code 21.
4. A youth attends high school 10 hours a week to finish two classes needed to graduate and works 20 hours a week. Submit Code 41.
5. A 35-year-old woman returns to college 10 hours a week to finish an accounting degree. Submit Code 41.
6. A youth is suspended for one week from attending high school full-time. No change is required: Code 21 still applies.
7. A youth is expelled from one high school and plans to apply to attend another, but is not yet enrolled. Submit Code 97.

Type: Text (2)

Valid Codes	Definition
	Education
21	Full-time education: (1-12 grade: 20+ hours per week; kindergarten and >12 grade: 12+ hours per week). A person is considered enrolled in school during scheduled vacations or term breaks that follow a period of enrollment as defined above.
41	Part-time education: (1-12 grade: less than 20 hours per week; kindergarten and >12 grade: less than 12 hours per week). A person is considered enrolled in school during scheduled vacations or term breaks that follow a period of enrollment as defined above.
97	Not in educational activities

Attribute: *Other Activity Code*

Transaction:
Activity Evaluation

Definition:
A code which describes the client's activity other than employment or education.

Procedure:
- Report the client's activities on assessment and when a change occurs.
- For On Change, report the actual date of the change. Where unknown, report the best estimate and document in the file.
- All activities listed here are **not** considered to fit the state definition of employment, paid or unpaid.
- This is a MHCADSD outcome measure.

Required Documentation:
Provider records shall document all activity including the source of information used to code this attribute.

Type: Text (2)

Valid Codes	Definition
	Other Activities
71	Other normal for age or culture - Participates in activities other than education or employment that are normal for most individuals of the client's age and culture, e.g., caregiver, homemaker.
98	No normative activity - Does not participate in any activities that are normal for the client's age or culture. This includes participating in treatment-oriented structured activity when this is the client's only activity.

Attribute: *Grade Level*

Transaction:
Activity Evaluation

Definition:
Identifies the highest grade level completed by the client. For GED, use code 12.

Type: Character (2)

Code	Definition
00	Preschool/kindergarten
01 – 12	List the specific grade completed
13	Some College or Technical training
14	2 year degree (AA, AS)
16	4 year degree (BA, BS)
18	Post-graduate education
90	Never attended or below preschool
99	Unknown

Transaction: Authorization Request

Definition:
The request from a provider for MHCADSD to authorize either a benefit or a program for a client; or the report from a provider to MHCADSD that a client does not meet medical necessity criteria for receiving services.

Required for:
All programs

Procedure:
Authorization request transactions for outpatient and residential benefits that are paid on a case rate basis must be posted by the last day of the calendar month following the assessment date.

Frequency:
On request for services (Medicaid only)
Assessment
On change (outpatient benefit only during first two months)

Transaction ID: 670.02

Action Codes:

A	Add Authorization Request

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Date of Assessment	Text (YYYYMMDD)	8	
Benefit/Program Requested	Text	3	Y
Benefit Change Code	Text	2	Y
Request Date	Text (YYYYMMDD)	8	
Authorization Number	Text (number)		
Team Service Flag (child)	Text	1	Y
King County ID	Text (number)		

Attribute: *Date of Assessment*

Transaction:
Authorization Request

Definition:
This is the date that a face-to-face assessment was begun for the purpose of submitting an authorization request for a client.

- For non-residential authorizations, this is the date of assessment.
- For residential authorizations, this is the date the client enters the facility.

Procedure:

- In general, the start date of the authorization is the date of the assessment.
- For benefit change codes 05, 07, submit the date of the new assessment.
- For a client who does not meet medical necessity criteria for the outpatient level of care, submit the date of the assessment or the scheduled date if the assessment did not take place.

Required Documentation:
Providers shall document the beginning and end dates of the assessment in provider records.

Examples:

1. A person was assessed on July 15, 2009. The assessment took two hours and was completed that day. Enter 20090715.

2. A homeless person was identified for services on February 3, 2009. The clinician began interaction with the client on February 17, 2009, and completed the assessment on March 2, 2009. Enter 20090217.

Type: Date (8)
YYYYMMDD

Attribute: *Benefit/Program Requested*

Transaction:
Authorization Request

Definition:
The outpatient or residential benefit or MHP-administered program (see Section V, Crisis Services Level of Care and Section IX, Additional Services) requested by a provider for a client assessed against medical necessity and program-specific criteria.

Procedure:
- Submit a separate request for outpatient or residential benefit or MHP-administered program from which a client will receive services.
- When a client does not meet medical necessity criteria for an outpatient benefit, submit "00" (no benefit requested) for benefit code requested. See Example 2.
- Each authorized outpatient or residential benefit or MHP-funded program from which a client receives services will have a unique authorization number assigned. (See "Authorization Number" attribute.) This number will link the client and service events with the outpatient or residential benefit or the MHP-funded program under which the service was delivered.
- See the King County Medical Necessity Criteria in:
  - Section VI, Outpatient Services Level of Care, Attachment A for information on outpatient benefit requirements, and
  - Section VII, Residential Treatment and Supportive Housing Services Level of Care for information on residential benefit requirements.
- The "Program Overlap Rules" document provides details on which programs can overlap and under what conditions. The "Program Overlap Rules" document is available on the MHCADSD Intranet site (http://mhd-intranet/) and in the ISAC Notebook.

Examples:
1. Based on an assessment, the provider requests an authorization for an outpatient benefit with a 2X case rate by submitting code "2X1." The authorization is approved by the MHP and is assigned an authorization number.

2. Based on an assessment, the provider determines that a client does not meet medical necessity criteria for the outpatient level of care and submits code "00" for benefit code requested. A "No benefit requested" (00) authorization record is created by KCMHCADSD IS and is assigned an authorization number.

3. During an outpatient benefit period, a client decompensates and the DMHPs approve the use of a hospital diversion bed. The provider submits a new authorization request using code 74.

Type: Text (3)

Valid Codes	Definition
Outpatient Level of Care	
2X1	Outpatient Benefit with 2X case rate
3A1	Outpatient Benefit with 3A case rate
3B1	Outpatient Benefit with 3B case rate
00	No benefit requested. Client did not keep appointment.
112	Assessment Only (OPB). Client did not meet medical necessity.
Additional Outpatient Services	
05	Municipal Mental Health Court
06	KC Regional Mental Health Court
09	PES Care Manager (Harborview ED)
25	Specialty Employment Program (SEP)
35	Geriatric Regional Assessment Team
48	FIRST – Pre Release
49	FIRST – Post Release
53	Mental Health Integration Program
57	PACT, Engagement
58	PACT, Enrollment
60	HOST/PATH Outreach
61	HOST - Intensive Case Management/Stabilization
65	Western State Hospital Intensive Community Support Program
66	Expanding Community Services Intensive Community Support and Recovery Program
67	Offender Re-Entry Community Support Program (ORCSP) – Pre Release
68	Offender Re-Entry Community Support Program (ORCSP) – Post Release
69	Integrated Dual Disorders Treatment
77	MIST Engagement
78	MIST Enrollment
82	FACT, Engagement
83	FACT, Enrollment
86	Regional Mental Health Court Peer Support
87	Forensic Intensive Supportive Housing
88	Co-Stars
90	Peer Bridger
101	Housing Voucher
103	Re-entry Case Management
104	Re-entry Boundary Spanner
105	Behavioral Treatment
107	MIDD Wraparound
108	Family Treatment Court Wraparound
109	Trauma Informed Care Grant
110	Transitional Recovery Program Mental Health Professional
111	Moral Reconation Therapy - Domestic Violence
113	Transition Support Program
114	HOME Outreach

Valid Codes	Definition
115	HOME Enrollment
151	Criminal Justice Liaison Program – South East (SE)
152	Criminal Justice Liaison Program – King Co Correctional Facility (KCCF)
153	Criminal Justice Liaison Program – Work and Education Release (WER)
154	Criminal Justice Liaison Program – Community Center for Alternative Programs (CCAP)

Crisis Level of Care	
13	Children's Crisis Outreach Response System (CCORS)
15	CCORS Intensive Stabilization Services
40	Adult Crisis Stabilization (including next day appointment)
74	Adult Inpatient Diversion Bed
75	Crisis Respite Program – DESC
76	Mobile Crisis Team
79	Crisis Diversion Interim Services
80	Crisis Diversion Facility Team
Residential Level of Care	
71	Adult Long-Term Rehabilitation Benefit
72	Adult Supervised Living Benefit
73	Adult Long-Term Rehabilitation Benefit (Benson Heights)
373	Standard Supportive Housing Benefit
374	FIRST Outpatient
Inpatient Level of Care	
IP	Inpatient Benefit {NOT SUBMITTED THROUGH THIS TRANSACTION; Entered by Authorizer through the CCS or Inpatient application.}

Attribute: *Benefit Change Code*

Transaction:
Authorization Request

Definition:
A code that indicates whether the authorization request transaction is for a new authorization or a change to an existing authorization.

Procedure:
- Codes ‘61’ or ‘69’ are used to request a provider change from an outpatient benefit to a new outpatient benefit. Once the new benefit goes to AA status, the previous benefit is automatically terminated.

Required Documentation:
The provider shall maintain records documenting the reason for the initial request or a change to an existing authorized outpatient benefit.

Examples:
1. A provider identifies a client as both eligible for and in need of services. The provider submits the first authorization request to provide services to the client. Use Code '01'.

2. A client who had an outpatient benefit that ended two weeks ago is reassessed and determined eligible for and in need of services. The provider submits an initial request for a 3A authorization. Use Code '01'.

3. A provider received an initial authorization for an outpatient benefit with a 2X case rate. Three weeks into providing services, the provider identifies a need for an outpatient benefit with a 3B case rate. Use Code '02'.

4. A provider requests an outpatient benefit for a client who currently has an outpatient benefit with another provider. The client wants to change providers for one of the valid reasons associated with the change codes '61'or '69'. The provider uses either '61' or '69' according to the reason for the provider change. The requesting provider may request whatever outpatient benefit case rate is determined appropriate. It is not necessary to request the same outpatient benefit case rate as the current authorization unless that is determined to be clinically appropriate.

Type: Text (2)

Valid Codes	Definition
00	No benefit was requested (use with programs '00' and '112')
01	Initial request for authorization.
02	Outpatient benefit case rate change - Request for a change in the outpatient benefit case rate for an existing authorization during the first two calendar months of the benefit. If approved, this code results in a change to the current outpatient benefit case rate, retrospective to the Start Date of the benefit. When this code is submitted after the second calendar month of the benefit, the request will be rejected. If an authorization has been approved (authorization status 'AA') the request will be rejected.
05	Next benefit - If approved, this code results in the creation of a new full-term outpatient benefit with a start date equal to the calendar day following the expiration date of the existing outpatient benefit. Note: The assessment date must fall within the last thirty days of the existing outpatient benefit.
07	Catastrophic Case Rate Change - Request for change in outpatient case rate change due to permanent, catastrophic change in client. If approved, this code results in the termination of the existing benefit and a new full-term outpatient benefit and case rate beginning the day of the reported assessment.
61	Provider Change - No cause provided. Clients may change providers without cause, and for any reason, during the first thirty (30) days of enrollment, and once every 12 months thereafter.
69	Provider Change - Other good cause; documented in client file.

Attribute: *Request Date*

Transaction:
Authorization Request

Definition:
The date the request is submitted by the provider.

Example:
1. Provider submits an authorization request on June 1, 2008. The request date is 20080601.

Type: Date (8)
YYYYMMDD

Attribute: *Authorization Number*

Transaction:
Authorization Request

Definition:
A unique number assigned by the MHCADSD information system (IS) to a particular authorized benefit (outpatient or residential) or to an authorization for an MHP-administered program (see Section V, Crisis Services and Section IX, Additional Services) or to report that a client does not meet medical necessity criteria for receiving services. The authorization number uniquely identifies the combination of client, authorized benefit/program, and benefit/program start date.

Procedure:
- This attribute is null for initial authorization requests. The authorization number will be assigned by the MHCADSD IS and returned in the authorization response report.
- The authorization number is required when the provider is submitting a request for next (i.e., continuing) benefits, case rate change, or provider change.
- For persons served under both a benefit (outpatient or residential) and one or more MHP-administered programs, separate authorization numbers will be issued for each benefit/program.

Required Documentation:
Providers shall record the authorization number in the client's records.

Examples:
1. A child is authorized to receive outpatient benefit services with a 2X1 case rate and an authorization number is provided (551234). Each time she receives a service during the benefit period, the provider must submit the authorization number (551234) with the HIPAA 837P transaction.

2. During the outpatient benefit, the child also receives services from the CCORS intensive stabilization services program. The provider of those services submits an authorization request transaction for program 15. The MHCADSD IS transmits an authorization response with a unique authorization number (559876). Each time services under this program are transmitted in the HIPAA 837P transaction, the authorization number (559876) must be used.

Type: Integer

Attribute: *Team Service Flag*

Transaction:
Authorization Request

Definition:
This attribute codes whether a child is certified by the MHP to receive outpatient benefit services by a team of providers. *Team* is defined as an individual treatment team that is assembled specifically for a particular child which includes, as appropriate, individuals from other social service systems who know and have direct contact with the child. The purpose of the team is to design and deliver an array of services to meet the child's unique and sometimes complex needs.

This code also identifies those youth aged 18 - 20 years who are served under an adult outpatient benefit.

Procedure:
- Code this attribute at the time of the assessment for outpatient benefits. Be careful to code this attribute correctly. Once the benefit is approved, this attribute can be changed only during the first two calendar months of the benefit.
- The edit rejects incompatibility between a coded value and the DOB.
- Regardless of the team service flag, all clients aged 18 - 20 years must have a GAF Scale score submitted, **not** CGAS. (See Diagnosis Codes).
- This code is only relevant for outpatient benefits. For clients under 18 years of age, submit code 1 or 2. For clients 18 - 20 years, submit either code 1 (to request a child benefit) or code 3 (to request an adult benefit). For clients 21 years or older, submit code 3.
- The submitted code cannot be changed through a batch transaction. To change the submitted Team Service Flag during the first two calendar months, contact the Help Desk to request the change.

Required Documentation:
Providers shall maintain copies of authorizations in client's records verifying that the client is certified to be served by a team.

Examples:
1. A client is 19 years old. At the time of assessment, it was decided to request authorization for an adult outpatient benefit rather than request service under a child's outpatient benefit (which has different clinical outcome measures). Code 3.

2. Authorization is requested for a client who will be served through a residential benefit or an MHP-administered program. Code 3.

Type: Text (1)

Valid Codes	Definition
1	The child is certified to be served by a team.
2	The child is not certified to be served by a team.
3	Not applicable - the client is served under an adult outpatient benefit or through a residential benefit or an MHP-administered program.

Transaction: Batch Footer

Definition:
This record should appear as the last record in each batch.

Procedure:
- The record count should **not** include the batch header or batch footer records.
- The edit program tests the record count value with the number of separate lines in the batch.

Required for:
Each batch

Frequency:
Every time a batch is submitted to MHCADSD IS.

Transaction ID: 999.01

Action Codes:
NONE

Attribute	Type	Size	Coded
Batch ID	Text (number)	5	
Date of Submittal	Text (YYYYMMDD)	8	
Source Organization ID	Text	3	Y
Record Count	Text (number)	5	

Transaction: Batch Header

Definition:
This record should appear as the first record in each batch. It identifies the batch ID, date of submission and the provider submitting the batch.

Required for:
Each batch

Frequency:
Every time a batch is submitted to MHCADSD IS.

Transaction ID: 000.03

Action Codes:
NONE

Attribute	Type	Size	Coded
Batch ID	Text (number)	5	
Date of Submittal	Text	8	
Source Organization ID	Text	3	Y

Transaction: Case Manager Contact Information

Definition:
Establishes case manager contact information in the State DSHS Regional Support Network (RSN) Demographic Search and also provides contact information for the responsible provider case manager/primary care provider in the MHCADSD IS.

Crisis workers use the RSN Demographic Search and the MHCADSD IS to locate and contact the case manager responsible for the care of a client.

See also Case Manager Link.

Required for:
All outpatient benefits, , Adult Long-Term Rehabilitation (71),
FACT enrollment (83), PACT enrollment (58),
HOST/PATH outreach (60), HOST - Intensive Case Management/Stabilization (61),
Co-Occurring Disorder Integrated Treatment Services (64),
Municipal Jail Transition Services (55), County Jail Transition Services (56),
Western State Hospital Intensive Community Support Program (65),
Expanding Community Services Intensive Community Support and Recovery Program (66),
ORCSP (previously CIAP) – Pre Release (67),
ORCSP (previously CIAP) – Post Release (68),
FIRST – Pre Release (48), FIRST – Post Release (49)

FACT and PACT enrollment providers will report Team Leader contact information.

Frequency:
On assignment
On change

Transaction ID: 100.03

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case Manager ID	Text	10	
Primary Case Manager Phone	Text	10	
Primary Case Manager Comment	Text	50	
Secondary Case Manager Phone	Text	10	
Secondary Case Manager Comment	Text	50	

Attribute: *Case Manager ID*

Entity:
Case Manager Contact Information

Definition:
This attribute links the Staff Person ID of the case manager with telephone contact numbers in order to provide 24-hour case management and crisis contact services for enrolled consumers.

The Primary Case Manager (case manager, therapist, other clinical staff designated by the provider) is the individual with primary responsibility for implementing a plan for outpatient mental health rehabilitation services to be provided to the client (WAC 388-865-0345).
The Secondary Case Manager can be used by the provider to identify an alternate 24-hour contact person.

Procedure:
- Enter the Staff Person ID of the responsible case manager in this field to identify the staff person who is the case manager /primary care provider.
- Providers have discretion in determining whether the primary and secondary case managers are the same or a different contact person, but must ensure the 24-hour availability of case management information.

Required Documentation:
Provider records shall document the identity of the primary care provider responsible for the coordination of care for a given client. Providers shall update the MHCADSD IS when there is a change in the identified primary care provider for a given client.

Valid Codes:
This code must be an existing, open Staff Person ID. Up to 10 characters are permitted.

Attribute: *Case Manager Phone*

Transaction:
Case Manager Contact Information

Definition:
The phone number by which case managers/primary care providers can be reached 24 hours per day, 7 days per week.

Procedure:
- Use the case manager phone to provide the numbers for the case managers listed. The telephone numbers will be used by crisis workers to contact clinicians responsible for the care of client.
- Use the "Case Manager Comment" attribute to provide detailed information for the phone numbers provided.

Example:
1. The primary case manager's telephone number is (206) 296-5213. Enter 2062965213. Do not use parenthesis, dashes, or spaces.

Type: Text (10)

Valid Codes:
No restrictions. Up to 10 characters are permitted.

Attribute: *Case Manager Comment*

Transaction:
Case Manager Contact Information

Definition:
A free-form field used to comment on case management team/primary care provider phone numbers.

Procedure:
- Use the primary case manager comment key to provide additional information about contacting the primary care provider who can be contacted by clinical care coordinators.
- Use the secondary case manager comment key to provide additional information about the contact person.

Example:
1. Comments might include: This is daytime number only; this number is for a beeper; this is the number to use after hours/on weekends, etc.

Type: Text (50)

Valid Codes:
No restrictions. Up to 50 characters are permitted.

Transaction: Case Manager Link

Definition:
This information is used to link individual clients with the case manager/primary care provider or practitioner responsible for implementing client care. A successful 'Case Manager Contact Information' transaction must have processed prior to submitting this 'Case Manager Link ' transaction.

Required for:
Outpatient

Frequency:
Initial assessment
On change

Transaction ID: 011.01

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Case Manager ID	Text	10	
Case Manager Reporting Unit ID	Text	3	Y

Attribute: *Case Manager ID*

Transaction:
Case Manager Link

Definition:
A code established by a provider to link each client with his/her case manager/primary care provider. (See WAC 388-865-0345.)

Required Documentation:
- Enter the Staff Person ID of the responsible case manager in this field to identify the staff person who is the case manager /primary care provider.
- Provider records shall document the name of the primary care provider/case manager responsible for the coordination of care for a given client.
- Client records shall include documentation of the date that the case manager was assigned and terminated (when applicable) from the client's case.
- Providers are responsible for updating the MHCADSD IS when there is a change in the identified primary care provider for a given client.

Valid Codes:
No restrictions. Up to 10 characters are permitted.

Transaction: Children's Functional Assessment Rating Scale

Definition:
The Children's Functional Assessment Rating Scale (CFARS) is an inventory that is used to assess the level of functioning of children and adolescents in a number of life domains.

Procedure:
- Scores on the CFARS are used to identify focuses for treatment and to determine whether the client achieves desired outcomes.
- Use the anchors below to rate the individual. Each item is listed as a separate attribute in subsequent pages.
- Report as the event date the required reporting date (as described under "Frequency"), using the most recent contacts with the client to rate his or her functioning.
- A report will be available in the Reports application that lists all upcoming CFARS reporting dates, as well as all past due CFARS data that have not been submitted and posted successfully to the ea_cfars table. Required data for an authorization will be considered past due unless a complete set of CFARS scores is posted from the provider for the client with an Event Date that is within 30 days of the required reporting date. If, because of a termination, two required reporting dates are within 60 days of each other, a single set of data will meet the requirement as long as the Event Date is no more than 30 days after the first reporting date and no more than 30 days before the second reporting date.

Coding Definitions:
Use the following anchors to rate the client on items A-P on the CFARS Problem Severity Rating Summary:

1 NO PROBLEM.
- Functioning is consistently average or better than what is typical for this person's age, sex, and subculture.
- There is no need for treatment.

2 LESS THAN SLIGHT PROBLEM

3 SLIGHT PROBLEM
- Functioning in this range falls short of typical for a person of this age, sex, and subculture most of the time.
- Problems may be intermittent or may persist at a low level.
- Problems have little or no impact on other domains or they are currently controlled by medications.
- The need for treatment is not urgent but may require therapeutic intervention in the future.

4 SLIGHT TO MODERATE PROBLEM

5 MODERATE PROBLEM

- Functioning in this range is clearly marginal or inadequate, not meeting the usual expectations of a typical person of this age, sex, and subculture.
- The dysfunction or problem may persist at a moderate level or become severe on occasion.
- Problems may be related to other domains and do require therapeutic intervention(s).

6 MODERATE TO SEVERE PROBLEM

7 SEVERE PROBLEM

- Functioning in this range is marked by obvious and consistent failures, never meeting expectations of a typical person of this age, sex, and subculture.
- The dysfunction or problem may be chronic.
- Problems almost always extend to other domains and generally interfere with interpersonal or social relationships with others.
- Hospitalization or some other form of external control may be needed in addition to other therapeutic intervention(s).

8 SEVERE TO EXTREME PROBLEM

9 EXTREME PROBLEM

- The highest level of the scale, suggesting the person's problem(s) is creating a situation that is totally out of control, unacceptable, and/or potentially life-threatening.
- The need for external control or intervention is immediate.

Required for:
Required only for:
Child Outpatient benefits (2X1, 3A1, 3B1) for which the first month of the benefit is paid with Mental Illness and Drug Dependency (MIDD) funds

Frequency:
For Child Outpatient benefits (2X1, 3A1, 3B1) at:
Authorization start, six months after authorization start, and authorization end. If an authorization is terminated before the original expiration date, the CFARS is required for the termination date.

Transaction ID: 650.01

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Event Date	Text (YYYYMMDD)	8	
Depression	Text (number)	1	Y
Anxiety	Text (number)	1	Y
Hyperactivity	Text (number)	1	Y
Thought Process	Text (number)	1	Y
Cognitive Performance	Text (number)	1	Y
Medical/Physical	Text (number)	1	Y
Traumatic Stress	Text (number)	1	Y
Substance Use	Text (number)	1	Y
Interpersonal Relationships	Text (number)	1	Y
Behavior in “Home” Setting	Text (number)	1	Y
ADL Functioning	Text (number)	1	Y
Socio-Legal	Text (number)	1	Y
Work or School	Text (number)	1	Y
Danger to Self	Text (number)	1	Y
Danger to Others	Text (number)	1	Y
Security Management Needs	Text (number)	1	Y
Authorization Number	Text (number)		
King County ID	Text (number)		

CFARS Definitions:

Definitions for the subscales of the CFARS can be found in the Children's Functional Assessment Rating Scale Manual available at: http://outcomes.fmhi.usf.edu/_assets/docs/cfarsmanual.pdf

Required Documentation:

- Completed CFARS must be maintained in provider records for each client required to be assessed with this instrument.
- Providers shall maintain records to identify the clinical staff person by name, degree, and working job title that assessed the client on the CFARS. The individual conducting the assessment can be anyone authorized by provider protocols to do so.

Type: Number

For CFARS "A" through "P":

Valid Codes	Definition
1	No Problem
2	Less than Slight Problem
3	Slight Problem
4	Slight to Moderate Problem
5	Moderate Problem
6	Moderate to Severe Problem
7	Severe Problem
8	Severe to Extreme Problem
9	Extreme Problem

Transaction: Client Demographics

Definition:
General demographic information that describes a person.

Required for:
All programs

Frequency:
Initial assessment
On change

Transaction ID: 020.06

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Event Date	Text (YYYYMMDD)	8	
Surname	Text	30	
Given Names	Text	30	
Gender	Text	1	Y
Date of Birth	Text (YYYYMMDD)	8	
Ethnicity	Text	45	Y
Hispanic Origin	Text	3	Y
Interpreter Required	Text	1	Y
Language Code	Text	2	Y
Sexual Minority Status	Text	1	Y
Military Status	Text	2	Y
Family Military Status	Text	2	Y
Social Security Number	Text (number)	9	
King County ID	Text (number)		

Attribute: Surname

Transaction:
Client Demographics

Definition:
The surname/family/last name of a client as provided by a Reporting Unit. In general, follow the rules of the appropriate culture when determining which name is the surname.

Procedure:
- Consistency is important; the last name will be used as one element to uniquely identify the person across our system.
- This is a required attribute.
- A null field will generate a fatal error.
- If the surname is unknown, you may enter, "UNKNOWN" (without the quotation marks). However, a reported value of "UNKNOWN" will **not** meet data timeliness requirements for outpatient or residential benefits paid on a case rate basis.
- Only the following characters are allowed: alphabetic characters, hyphens, space (but not as the first character), apostrophe (single quotation mark). No numeric characters are permitted.

Required Documentation:
The client's surname shall be included in his/her clinical record. Providers shall be required to update name changes.

Example:
1. If the surname is a hyphenated, include both names in the surname field using a hyphen between names. For instance**,** Gilbert-Richards is entered as Gilbert-Richards.

Type: Text (30)

Attribute: Given Names

Transaction:
Client Demographics

Definition:
The given/first/legal names of a client as provided by a reporting unit. In general, follow the rules of the appropriate culture when determining which name is the surname and which the given name.

Procedure:
- Consistency in reporting each client's name is important; the last name and given names will be used as elements to uniquely identify the person across our system.
- The middle name is a required entry. If only the middle initial is known, enter the middle initial. If there is no middle name, leave the field blank.
- The given name as recorded on significant documentation can be used to resolve contradictions. Use reasonable judgment to determine the best choice.
- Given names may include spaces, apostrophe (single quote) and hyphens. No numeric characters allowed.
- This is a required attribute.
- A null field will generate a fatal error.
- If the given name is unknown , you may enter "UNKNOWN" (without the quotation marks). However, a reported value of "UNKNOWN" will **not** meet data timeliness requirements for outpatient or residential benefits paid on a case rate basis.

Required Documentation:
The client's given name shall be included in the client's clinical record. Providers shall update/correct name changes as necessary.

Example:
1. Garry D. Richards, Jr. should be entered as Garry D Jr (dropping the period after the middle initial and the abbreviation).

Type: Text (30)

Attribute: Gender

Transaction:
Client Demographics

Definition:
A code that indicates the self-identified gender of a client or staff person.

Procedure:
- Indicate the gender of male or female. For transgendered persons, enter the self-identified gender.

Required Documentation:
Provider records must indicate that gender identification was self-identified.

Examples:
1. The client identifies herself as a female, born female. Use Code 1.
2. The client identifies herself as a female, born male. Use Code 1.

Type: Text (1)

Valid Codes	Definition
1	Female
2	Male

Attribute: *Date of Birth*

Transaction:
Client Demographics

Definition:
The date a person was born.

Procedure:
- If the exact day or the exact day and exact month are unknown, enter zeroes for the day and month.
- If the exact year is unknown, enter zeroes for the day and month and enter an approximate year.

Required Documentation:
Providers shall maintain documentation describing the source of information from which the date of birth was established.

Examples:
1. The client provided a driver's license showing a birthdate of February 11, 1937. **Enter 19370211.**

Type: Text (8)
YYYYMMDD

Attribute: Ethnicity

Transaction:
Client Demographics

Definition:
This code is used to indicate the client's ethnicities as reported by the client.

Procedure:
- Enter all the codes that best describe the client's self-reported ethnicities.
- If the information is not available or unknown, then use code 999 . Do not use code 999 with any other code combinations.

Every person shall have both at least one Ethnicity code and a Hispanic indicator code (see "Hispanic Origin"). This is a Federal requirement, established by the Bureau of the Census.

Required Documentation:
Vendor records shall document the ethnicities of the client and verify that the client reported this information.

Examples:
1. A client self-identifies as both White and Chinese would be coded as 010605. The first three digits (010) represents the first ethnicity, the second three digits (605) are the next ethnicity and so on.
2. A client self-identifies as Cambodian, code 604.

Type: Text (45)

Valid Codes	Definition
Detail Codes	**All Programs**
010	White / Caucasian
021	American Indian or Alaska Native
031	Asian Indian
032	Native Hawaiian
033	Other Pacific Islanders
034	Other Asian
040	Black, African American or Negro
050	Some Other Race
604	Cambodian
605	Chinese
608	Filipino
611	Japanese
612	Korean
613	Laotian
618	Thai
619	Vietnamese
660	Guamanian or Chamorro

Valid Codes	Definition
Detail Codes	**All Programs**
695	Samoan
699	Other Asian / Pacific Islander – Internal MHCADSD use only. **Code not available for providers' use after 12/31/2001.**
871	African - Ethnic
999	Not Reported / Unknown

Attribute: *Hispanic Origin*

Transaction:
Client Demographics

Definition:
A person of Mexican, Puerto Rican, Cuban, Central American, South American or other Spanish origin or descent, regardless of race.

Procedure:
- Roll-up code "000" may only be used by crisis services.
- Use the code that describes the person's self-identification with Hispanic culture, origin or descent, **in addition to** the ethnicities recorded under Ethnicity.
- This is a state-required field.

Note: Every person shall have an entry for both Ethnicity and Hispanic indicator.

Required Documentation:
Providers shall document whether or not a client identifies with any Hispanic culture. Records shall document that Hispanic cultural identification was self-identified by the client, or, for children younger than 13 years, by the client's parent or legal caregiver.

Examples:
1. A client self-identifies himself as Puerto Rican. Code 727 for the "Hispanic Origin" attribute. The same client states his ethnic group is African American. Code 040 for the attribute "Ethnicity."
2. A client self-identifies as White/Caucasian, code 010 for the attribute "Ethnicity." When asked if she also identifies with any Hispanic culture, the client states that she does not. Code 998 for the "Hispanic Origin" attribute.

Type: Text (3)

Valid Codes	Definition
000	General Hispanic - May only be used for crisis services
709	Cuban
722	Mexican/Mexican-American/Chicano
727	Puerto Rican
799	Other Spanish/Hispanic
998	Not Spanish/Hispanic
999	Unknown

Attribute: *Interpreter required*

Transaction:
Client Demographics

Definition:
This code is used to identify a person who, in the opinion of either the case manager or the client, is functionally monolingual and needs the assistance of an interpreter or staff who speaks his/her language in order to request or receive appropriate mental health services.

Procedure:
- Enter the code 2 - YES if the person, because of a limited ability to speak English, requires the assistance of an interpreter in order to communicate effectively with regard to the course of their treatment.
- Limited English Proficiency does not include persons who are English speakers but who require assistance in reading.
- For children, if the child is fluent in English but a family member who is in treatment with the child requires the assistance of an interpreter, code this field 2 - YES.

Required Documentation:
When code 2 is used, documentation must indicate that interpretive services are provided to the client or to the client's family member who is also in service and requires interpretive services.

Examples:
1. A client's primary language is Spanish, but she has some ability to speak English. However, when this client is experiencing a mental health crisis, she needs interpretive services in order to communicate effectively. Code 2.
2. A 12-year-old client is proficient in English. His mother is also receiving mental health services and only speaks Korean. Code 2.
3. A client's primary language is Russian. He's receiving residential services from provider staff who speaks Russian. Code 2.

Type: Text (1)

Valid Codes	Definition
1	No - the person does not require an interpreter.
2	Yes - the person requires the assistance of an interpreter.
9	Unknown - the English language proficiency of the person is unknown / unavailable **,**

Attribute: Language Code

Transaction:
Client Demographics

Definition:
This code identifies the language in which a person prefers to receive services.

Procedure:
- This is **not** an indicator of fluency in English.
- Use the attribute "Interpreter Required" to describe fluency in English in the context of treatment.
- This is a state-required field.

Required Documentation:
Provider records shall document the client's current preferred language.

Type: Text (2)

Valid Codes	Definition
00	Language Unknown
01	Japanese
02	Korean
03	Spanish
04	Vietnamese
05	Laotian
06	Cambodian
07	Mandarin
08	Hmong
09	Samoan
10	Ilocano
11	Tagalog
12	French
13	English
14	German
15	American Sign Language
16	Cantonese
17	Hungarian
18	Russian
19	Romanian
20	Polish
21	Greek
22	Tigrigna
23	Amharic
24	Finnish
25	Farsi

Valid Codes	Definition
26	Czech
27	Mien
28	Yakima
29	Salish
30	Puyallup
31	Thai
32	Portuguese
60	Italian
81	Other African
82	Other Native American
83	Other Filipino Dialect
85	Other Asian
87	Other communication methods (e.g., lip-reading, finger-spelling, letterboard, cued speech)
99	Other Language

Attribute: *Sexual Minority Status*

Transaction:
Client Demographics

Definition:
This code describes the client's stated sexual orientation. A member of a sexual minority is any person who self-identifies as:
a) being a lesbian; or
b) being a gay male; or
c) being bi-sexual; or
d) being transgendered; or
e) exploring/considering her/his sexual orientation and/or gender identity

Procedure:
- Note that sexual identification should not be inferred by the clinician. It must be self-reported by the person.

Required Documentation:
Providers must provide documentation indicating that a client stated his/her sexual orientation. If information is unknown at the time of assessment, but the client's sexual orientation becomes known at a later date, providers are responsible for updating the clinical record and the MHCADSD IS.

Example:
1. A client states she is a lesbian. Code 2.

Type: Text (1)

Valid Codes	Definition
1	The person states he/she is heterosexual
2	The person states that he/she is a member of a sexual minority as defined above.
8	Not asked - the question was not asked or client did not self-identify. Also use this code for child under age 13.
9	Unknown - this information is not available at present.

Attribute: *Military Status*

Transaction:
Client Demographics

Definition:
This code indicates whether the client has served in any branch of the United States military (Army, Navy, Marines, Air Force, Coast Guard), including service in the National Guard or Reserves.

Procedure:
- At a minimum, the provider should ask all adults who receive services whether they have ever served in the U.S. military. More information may be gathered for clinical or case management reasons but is not required for this attribute.

The provider shall maintain documentation of the source of information for the client's military status.

Required Documentation:
The provider shall document in the clinical file the source of information about the client's military status.

Example:
1. Client said he was in the Coast Guard forty years ago. Code 01.
2. Client said he had been in the Army Reserves. He was not sure if he had been on active duty or not. Code 01.
3. When asked if he had ever served in the U.S. military, client was uncertain and said he couldn't remember. Code 09.

Type: Text (02)

Valid Codes	Definition
01	The person served in the U.S. military
02	The person has never served in the U.S. military
08	Not asked - the question was not asked or client refused to answer. Also use this code for child under age 18.
09	Unknown - this information is not available at present .

Attribute: *Family Military Status*

Transaction:
Client Demographics

Definition:
This code indicates whether the client is the dependent child (18 or under), spouse, or domestic partner of someone who served in any branch of the United States military (Army, Navy, Marines, Air Force, Coast Guard), including service in the National Guard or Reserves. A minor dependent is the veteran's biological/adopted child under 18, regardless of living situation or guardianship, until such time as they age into adulthood, are legally adopted by someone else, or are granted legal emancipation.

Procedure:
- At a minimum, the provider should ask each person (or parent/guardian if a young child), who receives services whether the client is the dependent child, spouse, or domestic partner of someone who served in the United States military. More information may be gathered for clinical or case management reasons, but is not required for this attribute.

Required Documentation:
The provider shall document in the clinical file the source of information about the client's family military status.

Examples:
1. Sixteen year-old client said his mother had served in the Army before he was born - Code 01.
2. Thirty-five year-old client said her husband was in the Air Force. She was not sure if he had been on active duty or not - Code 02.
3. The biological father of a 15-year-old client in foster care had served in the Army and suffered serious injury; neither of her foster parents served - Code 01.

Type: Text (2)

Valid Codes	Definition
01	Dependent child of a person who served in the U.S. military.
02	Spouse or domestic partner of a person who served in the U.S. military.
03	Neither the dependent child, nor the spouse or domestic partner of a person who served in the U.S. military.
08	Not asked - the question was not asked or client refused to answer.
09	Unknown - this information is not available at present.

Attribute: *Social Security Number*

Transaction:

Client Demographics

Definition:
This is the social security number (SSN) assigned to the client.

Procedure:
- Report the date of the assessment when reporting this attribute.
- Do not use a parent's SSN for a child or a spouse's SSN. If the client does not have his own SSN, or SSN is unknown, use code 999999999.

Required Documentation:
- The provider shall maintain documentation identifying the source of information for the client's SSN.
- If 999999999 is submitted, providers are required to update the MHCADSD IS when SSN information is provided.

Example:
1. The client verbally provided the number; the client showed his/her social security card; the SSN was shown on a third-party funder's document. Enter the number with no dashes or spaces.

Type: Text (9)

Valid Codes	Definition
	Social Security Number
999999999	Unknown

Attribute: *King County ID*

Transaction:
Client Demographics

Definition:
The unique King County identifier assigned to a client after the KCRSN/IS has unduplicated client records across all King County provider agencies.

Procedure:
- This identification number, provided by the MHCADSD IS, uniquely identifies a client serviced by the King County RSN/MHP.

Required Documentation:
This number must be maintained in the client's record.

Type: Integer

Transaction: Conditions at Assessment

Definition:
Describes a condition, circumstance, or risk applicable at the beginning of the benefit.

Procedure:
- The presence of one or more of these conditions may be required to support authorization to a benefit or to support the priority authorization of a non-Medicaid client.
- Submit one transaction for each applicable condition, risk, or circumstance.

Required for:
Outpatient benefit only for all Medicaid-enrolled children and youth and for non-Medicaid authorization to indicate immigrant status for all ages.

Frequency:
Assessment

Transaction ID: 617.01

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Assessment Date	Text (YYYMMDD)	8	
Condition Code	Text	3	Y
King County ID	Text (number)		

Attribute: *Condition Code*

Transaction:
Conditions at Assessment

Definition:
These codes identify specific conditions and circumstances, risk indicators, medical necessity, and other indicators noted during the assessment that impact eligibility.

Procedure:
- The clinician must document and report every condition or circumstance applicable.
- Submit one transaction for every applicable condition, circumstance, or risk indicator.

Required Documentation:
- Chart notes documenting clinical interviews with the child, primary caretaker and any other significant adult.
- Written referral material from social service evaluations, court documents, or other clinical programs when available at initial evaluation shall also be maintained.
- Attempts at corroboration are desirable and, if they are not completed by the time of the clinical review, attempts at acquiring corroborating documentation shall be noted in the chart.

Example:
A four-year-old girl is referred for therapeutic day care by the University of Washington Teratology Clinic with a written evaluation documenting Fetal Alcohol Syndrome and documenting Inadequate Parenting and Child Neglect. On interview, the child discloses corroborated inappropriate sexual contact with the mother's boyfriend. Enter codes for Fetal Alcohol Syndrome/Effect (103), Inadequate Parenting and Child Neglect (133), and Sexual Abuse (135).

Type: Text (3)

Children's Conditions

Valid Codes	Definition
	Children's Conditions - Medical Necessity
101	**Chronic medical condition that may affect psychological functioning:** A chronic medical condition, evaluated and diagnosed by a physician, which impacts the child's and his/her family's daily life due to functional limitations, needs for medication and/or rehabilitative activity. This condition shall be limited to any medical condition that does not directly affect the brain and its functioning. It excludes all neurological conditions that affect the function of the brain with direct impact on personality and functioning in the environment. (See 102.) Examples of general medical conditions that may affect psychological functioning are juvenile diabetes and asthma.
102	**Neurological Condition Affecting Psychological Functioning**: A chronic neurological condition, evaluated and diagnosed by a physician, which impacts the child's and his/her family's daily life due to functional limitations, needs for medication and/or rehabilitative activity. This condition is limited to neurological conditions with a direct physiological effect on brain function with the exception of Fetal Alcohol Syndrome (See 103). The brain lesions directly affect personality and functioning. Examples of neurological conditions that may affect psychological functioning are seizure disorders, particularly temporal lobe seizures, or an intractable headache syndrome.
103	**Fetal Alcohol Syndrome/Effect or Fetal Drug Exposure**: A chronic static brain injury sustained due to intrauterine exposure of a substance toxic to the fetus which impacted brain development. Compelling evidence of FAS/E or FDE includes a history of alcohol and/or drug use by the patient's birth mother during pregnancy and current symptoms of impulsivity and/or age inappropriate judgment with or without physical stigmata or retardation. To be coded, this condition must have been formally evaluated and diagnosed by a child psychiatrist or any other physician with special interest and experience in evaluating these conditions, or there must be compelling current evidence of symptoms or history of fetal exposure. Mental status examination on assessment must corroborate symptom history for an undiagnosed child and plans for a physician evaluation shall be documented in the chart. Consideration of a differential diagnosis must be evident in the record of the evaluation.

Valid Codes	Definition
104	**Developmental Disorder**: Must be a diagnosable (DSM IV, Axis I, II or III criteria) condition. A Developmental Disability shall be defined as a condition described in the DSM IV under "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence" specifically, diagnoses listed under "Mental Retardation," "Learning Disorders," "Motor Skills Disorder," and "Communications Disorders." It specifically excludes Pervasive Developmental Disorder. Mental retardation is the Axis II diagnosis specific to child or adolescent developmental disorders. Examples of Axis III conditions which may be cited are failure to thrive and malnourishment syndromes.
105	**Learning Disability:** Difficulties with academic tasks which have been diagnosed with psychological and/or educational testing and documented by a school system in a Focus of Concern (or similar) process. This condition does not include educational designations of Seriously Behaviorally Disturbed. (See 106.)
106	**Seriously Behaviorally Disturbed**: The presence of an educational system designation of SBD discerned through a Focus of Concern (or similar) process. The SBD designation is the result of patterns of behavior that disrupt the child's process of learning and may or may not meet criteria for a psychiatric Axis I or II diagnosis.
None - Use Disability	**Substance Abuse in a Child**: Report using the "Substance Abuse" attribute in the Disability transaction, a substance abuse problem during the 90 days prior to assessment significant enough to meet DSM IV criteria and reported on the "Diagnosis Axis" and "Diagnosis Code" attributes. A substance use disorder may be cited on assessment when there is compelling evidence or history of a pattern of use which impacts the function of the child. A qualified professional must subsequently confirm this diagnosis. Documentation of such an evaluation, or plans for such an evaluation, shall be evident in the record. A qualified professional shall be defined as a certified chemical dependency professional with training and experience with children and adolescents, a board certified or eligible child and adolescent psychiatrist or a general psychiatrist with training or experience with adolescent psychiatry.
108	**Law Breaking Behavior in Child**: A child or adolescent with a pattern of behavior that regularly violates the law or a child who has committed a single serious legal offense (or time limited cluster of offenses). This condition refers to behavior that has caused a child or adolescent to be adjudicated by a court as a juvenile offender or behavior which is part of the child's medical or social history that, if found to be fact in a legal hearing, would lead to adjudication.

Valid Codes	Definition
109	**Attachment Difficulties**: A child whose current behavior indicates absent, weak or troubled attachments and has a history of disrupted parenting before age five. Examples of disrupted parenting are multiple placements, frequent disruptions in members of the household, or mental or physical disorders in the patient's primary caretaker that diminished availability for parenting. A diagnosis of reactive attachment disorder may be present or strongly suspected for these children when young and the symptoms of this syndrome may persist into late childhood and adolescence though modified as per developmental status.
110	**Multiple Systems Involvement:** Identifies whether the child is involved with one or more formal systems, in addition to mental health, within the preceding 12 months. Involved means the person is or has received services from formal systems. Formal systems can include but are not limited to schools, juvenile rehabilitation, alcohol/substance use disorder treatment, child or adult protective services, child welfare services, developmental disability services, vocational rehabilitation, etc. Schools can count as one system if the client is assessed for a child's outpatient benefit. Involvement with schools does **not** mean school attendance. It means the ongoing involvement of school counseling, special education systems, etc.
111	**Receiving Special Education Services:** The child has been determined to be eligible and is receiving services in accordance with the federal Individuals with Disabilities Education Act, and Washington Administrative Code 392.172.
112	None of the conditions are present based upon the intake assessment.

Children's Circumstances

Definition:
These codes identify specific circumstances noted during the assessment.

Procedure:
- Submit one transaction code for every circumstance applicable.
- Some clients will have codes for multiple circumstances. Some circumstance definitions preclude use of another.

Required Documentation:
- Documentation of clinical interview with child, primary caretaker and any other significant adult.
- Written referral material from social service evaluations, court documents or other clinical programs when available at initial evaluation.
- Attempts at corroboration are desirable and if not completed by the time of clinical review, attempts at acquiring corroborating documentation shall be noted in the chart.

Example:
1. A five-year-old boy witnessed the shooting death of his mother by his father (code 137, 138). This occurred as the culmination of a long-standing pattern of fighting in which the father had physically assaulted the aunt and mother (code 131, 136). The father had a diagnosis of alcoholism and when drunk regularly beat the patient (code 134, 143). The mother, who was the primary caretaker of the child most hours of the day, was mentally retarded and had a pattern of leaving the child alone while she was off with a friend (code 133, 146).

Valid Codes	Definition
	Children's Circumstances - Medical Necessity
131	**Family Discord**: A circumstance in which there is a significant pattern of discord in the family to which the child is exposed or in which he/she is a participant. A significant pattern identified for this circumstance is a pattern of arguing, verbal and mild physical altercations, traumatic disruptions in the household, property damage or disagreements sufficient to interfere with the primary functions of the family to nurture children and provide mutual support for adults. Serious parent/child conflict is included. Such patterns must be persistent and must involve at least two individuals. As such this definition excludes the case of an oppositional and defiant youth who is the sole disruptive force in an otherwise well-functioning family. The definition does not exclude but may not necessarily include domestic violence. Use code based on history obtained at assessment and documented in the record. The documentation may include any referral information.
132	**Out-of-Home Placement**: A circumstance in which the child or adolescent has had a significant disruption in his/her living situation due to being placed outside his/her home. A significant disruption is defined as at least one out of home placement greater than one week in the year prior to assessment. The placement outside of the child or adolescent's home must be due to the parent's or guardian's inability to care for the child or meet his/her needs. This may include cases where the primary problem is due to dysfunctional parents as well as cases where the primary problem is with the child who has overwhelmed otherwise competent parents. Use code based on history obtained at assessment and documented in the record. The documentation may include any referral information Compare this definition to the "Out of Home Placements" in the Outcome Count transaction.

Valid Codes	Definition
133	**Inadequate Parenting/Child Neglect:** A circumstance in which there is a persistent pattern involving inadequate care for the child or adolescent. Inadequacy as defined for these circumstances may be due to the parents or guardians having poor skills or inadequate knowledge of raising a child, or it may be due to the parents being preoccupied with their own difficulties. The care and supervision of the identified child/adolescent needs to be sufficiently poor as to compromise his/her health and welfare. The parents could be providing adequate care for another child in the family while their care for the patient may be grossly inadequate due to the child's special needs or special vulnerability. Use code based on history obtained at assessment and documented in the record. The documentation may include any referral information.
134	**Physical Abuse:** A circumstance in which there has been physical abuse to the child to such a degree that a professional is legally bound to report the circumstances to DSHS Child Protective Services. Physical abuse is defined for this circumstance as an act of physical restraint, assault or threat of assault, or any other form of physical intrusion onto the body of a child or adolescent which is hostile in intent, disrespectful of the child's physical integrity, and/or grossly insensitive to the child's developmental need for privacy, sense of safety, and physical integrity. Such acts must be performed by an individual sufficiently older and/or larger as to create an adverse power differential for the child. This definition excludes such acts as can be characterized as sexual. (See 135.) Use code based on history or disclosure obtained at assessment and documented in the record. The documentation may include any referral information.

Valid Codes	Definition
135	**Sexual Abuse**: A circumstance in which there has been sexual abuse to the child to such a degree that a professional is legally bound to report the circumstances to DSHS Child Protective Services. The circumstance of sexual abuse is defined as existing when the child or adolescent is the victim of inappropriate sexual interest by an adult or an individual sufficiently older or more powerful to preclude legal consent. In the case of adolescents, this age and power differential is such that the child is unable to exercise control or consent over the interaction. This attention may be an overt physical sexual act such as would meet legal definitions for rape or molestation. It may also be a pattern of sexual harassment or inappropriate sexualized attention. In addition to inappropriate sexual interest, sexual abuse according to this definition includes inappropriate exposure to adult sexuality such as witnessing the sex acts of family members or being exposed to pornography. This definition presumes that when sexual abuse is present it either creates in the child a sense of threat to physical or psychological integrity, or is inconsistent with the child's psychosexual developmental status. Use code based on history or disclosure obtained at assessment and documented in the record. The documentation may include any referral information.
136	**Domestic Violence**: A circumstance in which there is an act or pattern of physical violence or threats of violence between members of the child's household which have led to (or could lead to) bodily harm. This definition excludes acts or threats of violence specifically aimed at the child. Such acts or threats are coded as physical abuse (134) and may coincide with domestic violence. Use code based on history obtained at assessment and documented in the record. The documentation may include any referral information.
137	**Child Witness to Violence or Traumatic Death**: A circumstance in which a child or adolescent has been a direct witness to an act of violence in the community (not indirectly such as in a movie or on television). This may include both willful acts of violence between individuals, or accidental violence which may or may not have led to death but has involved severe bodily harm. This circumstance is not coded when the acts of violence are witnessed in the home as part of a pattern of domestic violence between household members (136) but may be coded if the child was a witness to a traumatic death in the home. Use code based on history obtained at assessment and documented in the record. The documentation may include any referral information.

Valid Codes	Definition
138	**Death of a Parent**: A circumstance in which the child has suffered the death of a parent. Death of a parent is broadly defined to include the death of the "psychological parent" or an adult who has functioned as a primary caretaker with whom the child has a parental bond. Examples of psychological parents might be a grandmother or aunt functioning as a parent, a long-term foster parent, or a step-parent. The death of a parent shall be documented in the record based on history as derived from the assessment and referral material. The significance of the loss of a presumed psychological parent who has died will be made and documented in the record as part of the assessment. Use code based on assessment and referral data.
139	**Troubled Sibling**: A circumstance in which there is a sibling in the identified client's family who is significantly troubled. Significantly troubled is defined as requiring a disproportionate amount of the family's time and resources so as to impact on the daily life of the identified client. The sibling may be affected with mental health, substance use disorder, medical problems or may have a developmental disability or juvenile justice problems. Use code based on history obtained at assessment and documented in the record. The documentation may include any referral information.
140	**Suicidal Behavior in a Parent**: A circumstance in which the child has had a significant exposure to the suicidal behavior of a parent. Significant exposure is defined as requiring one of two circumstances: (1) The child's parent has made a suicide attempt or parasuicide in the past year; or (2) The suicidal behavior was in the more distant past but after the birth of the child and the behavior was repetitive, serious and affected the parent's ability to parent the child. Parasuicide is defined as an act of self-harm which may or may not be intended to cause death but which yields observable damage to body tissues. Use code based on history obtained at assessment and documented in the record. The documentation may include any referral information.
141	**Divorce/Separation of Parents**: A circumstance in which the parents have moved from living together to living separately during the child's lifetime. The separation may or may not involve parental abandonment or conflict regarding child custody issues. Use code based on history obtained at assessment and documented in the record. The documentation may include any referral information.

Valid Codes	Definition
142	**Health Problems in Parents**: A circumstance in which the parent has a chronic health problem diagnosed by a nurse practitioner or physician requiring ongoing treatment or management. For this circumstance to be cited, the health problem of the parent must be sufficient to cause or threaten significant disruption in the overall functioning of the parent and in his/her capacity to attend to parental duties. Use code based on history obtained at assessment and documented in the record. The documentation may include any referral information.
143	**Substance Abuse in Parents:** A circumstance in which a parent has a substance use disorder diagnosed by a chemical dependency professional or physician requiring ongoing treatment or management. For this circumstance to be cited, the substance use disorder of the parent must be sufficient to cause or threaten significant disruption in the overall functioning of the parent and in their capacity to attend to their parental duties. Use code based on history obtained at assessment and documented in the record. The documentation may include any referral information.
144	**Parents Involvement in Criminal Justice System:** A circumstance in which the parent has a criminal justice problem characterized by having been convicted of a crime and subject to a legal consequence or the parent is significantly involved in responding to charges of crimes as to be required to expend significant amounts of time and resources. For this circumstance to be cited, the criminal justice problem of the parent must be sufficient to cause or threaten significant disruption in their overall functioning and in their capacity to attend to their parental duties. Use code based on history obtained at assessment and documented in the record. The documentation may include any referral information.
145	**Mental Illness in Parents**: A circumstance in which the parent has a chronic mental health problem diagnosed by a psychiatrist or qualified mental health specialist requiring ongoing treatment or management. For this circumstance to be cited, the mental health problem of the parent must be sufficient to cause or threaten significant disruption in their overall functioning and in their capacity to attend to their parental duties. Use code based on history obtained at assessment and document in the record. The documentation may include any referral information.

Valid Codes	Definition
146	**Cognitive Impairment in Parents**: A circumstance in which the parent has a cognitive impairment diagnosed by psychological testing and/or medical/psychiatric or advanced nurse practitioner evaluation which requires ongoing management and support services. For this circumstance to be cited, the cognitive impairment of the parent must be sufficient to cause significant incapacity in their overall functioning and in her/his capacity to attend to parental duties. Use code based on history obtained at assessment and documented in the record. The documentation may include any referral information.
147	**Child's Parent(s) Teens:** The circumstance of either parent being 18 or younger at the time the child was born. Use code based on history obtained at assessment and documented in the record. The documentation may include any referral information.
148	**Teen Parenthood or Pregnancy**: A circumstance in which an adolescent client is a teen parent, has been pregnant but aborted, or gave up the child for adoption. Teen parenthood and adolescent pregnancy are defined by the client becoming pregnant at age 18 or younger or, in the case of males, fathered a child at age 18 or younger. Use code based on history obtained at assessment and documented in the record. The documentation may include any referral information.
149	**Harassment or Abuse by Peers**: A circumstance in which a child or adolescent suffers a persistent pattern of abuse by peers. Harassment and abuse by peers is defined as a pattern of peer relationships in which a child or adolescent client is selected for harassment, physical or verbal abuse, derision and torment by more than one peer and that the child demonstrates no, or inadequate, coping skills to address the abuse. The child may or may not have actively participated in the set up for ill treatment by peers. The child may or may not have effective parental or adult support in dealing with such problems. Use code based on history obtained at assessment and documented in the record. The documentation may include any referral information.
150	**Cultural or Sexual Minority Status Where Context Creates Risks**: A circumstance in which the fact of cultural or sexual minority status creates risk to emotional wellbeing due to the social context which condones or provokes racial, cultural, or sexual minority-based harassment and intolerance. Use code based on history obtained at assessment and documented in the record. The documentation may include any referral information.

Valid Codes	Definition
151	**Multiple Moves**: A circumstance in which the child makes a move in primary residence, with or without his/her family, more than three times in the year preceding the assessment. Use code based on history obtained at assessment and document in the record. The documentation may include any referral information.
402	**Homelessness, Children**: A circumstance in which a child, with or without their family, sustains at least one episode of homelessness during past year. To be homeless one must have no identified place of residence and must have been in that status for longer than one week. If the child is homeless without his/her family, the child is unable to return to a parental home or the home of a previous guardian. An identified place of residence for a child or adolescent is the parental home, a placement sanctioned by the parents informally such as with a relative or close family friend, or a placement ordered by the court in a formal placement process. Inability to return to a parental home or previous placement must be due to: (1) the absence of such a home; (2) the fact that the child has actively been forced out of the parental home or previous placement and is unwelcome there; or (3) the court has intervened to prevent the return of the child to an unsafe previous home. Use code based on history obtained at assessment and documented in the record. The documentation may include any referral information. See also "Other Indicators." **Homelessness, Adults:** See Residential Arrangement transaction.

Risk Indicators

Definition:
These codes (currently only one) identify specific risk indicators noted during the assessment. These codes designate that a non-Medicaid person qualifies for enrollment in the MHP due to an acute need of service.

Procedure:
- Submit one transaction code for each applicable risk indicator.
- Document and report every condition applicable to the client.

Required documentation:
- Chart notes documenting clinical interview with client, primary caretaker, and any other significant adult.
- Written referral material from social service evaluations, court documents, or other clinical programs when available at initial evaluation.
- Attempts at corroboration are desirable and if not completed by a time of clinical review, attempts at acquiring corroborating documentation will be noted in the chart.

Examples:
1. A seven-year-old girl has disclosed to her care worker that she has been sexually abused. This was reported to CPS and evaluated by that agency which found that the allegations were substantiated. Prosecution of the stepfather is pending (code 201).

Valid Codes	Definition
	Risk Indicators - Acute Need of Services
314	**Refugee or Immigrant - Adult**, Children of Refugee or Immigrant – Child. This code is used to indicate that the client is in acute need of services because of this status as defined under the non-Medicaid policy. See Section II, Purpose of the Prepaid Health Plan. No time restrictions apply. This code replaces code 304 – Refugee or Immigrant in the past calendar year.

Transaction: Co-Occurring Disorders Assessment

Definition:
The Co-occurring disorders assessment quadrant value.

Required for:
Outpatient, Residential: When the individual scores a 2 or higher on either of the first two scales (ID Screen & ED Screen) and a 2 or higher on the third (SD Screen). See the Co-Occurring Disorders Screen for more information.

Frequency:
See COD Screening frequency requirements.

Transaction ID: 791.01

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Event Date	Text (YYYYMMDD)	8	
Quadrant	Text	1	Y
Authorization Number	Text (number)		
King County ID	Text (number)		

Attribute: Co-occurring Disorders Quadrant

Transaction:
Co-occurring Disorders Assessment

Type: Character (1)

Code	Definition
1	Less severe mental health disorder/Less severe substance use disorder
2	More severe mental health disorder/Less severe substance use disorder
3	Less severe mental health disorder/More severe substance use disorder
4	More severe mental health disorder/More severe substance use disorder
9	No Co-occurring treatment need

Procedure:
- The COD assessment is a quadrant assignment only.
- The COD assessment is required for clients 13 and over.
- When reporting an assessment, a value must be submitted.

Required Documentation:
Justification for all quadrants must be provided in agency records. Documentation must include: the date the quadrant was assigned; the name, title, and credentials of the clinician who assigned the quadrant; and a justification for the quadrant.

Transaction: Co-Occurring Disorders Screening

Definition:
Identifies the outcome of a screening using *GAIN Short Screen* (GAIN-SS) tool.

Required for:
Outpatient, Residential, Crisis

Frequency:
Initial assessment
Crisis episode – only if not completed (by any provider) in the previous 12 months.

Transaction ID: 790.01

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Event Date	Text (YYYYMMDD)	8	
IDS Score	Text	1	Y
EDS Score	Text	1	Y
SDS Score	Text	1	Y
Authorization Number	Text (number)		
King County ID	Text (number)		

Attribute: *IDS Score*

Transaction:
Co-Occurring Disorders Screening

Definition:
The Internal Disorder Screener (IDS) is designed to identify people experiencing internalizing disorders such as depression, anxiety, suicidal ideation, and acute/post-traumatic stress disorders.

Type: Text (1)

Valid Codes	Definition
0-5	Score in the range from 0 to 5
8	Refused
9	Not Completed

Attribute: EDS Score

Transaction:
Co-Occurring Disorders Screening

Definition:
The External Disorder Screener (EDS) is designed to identify persons experiencing externalizing disorders such as attention deficit, hyperactivity, conduct disorder, aggression/violence, and other externalizing behavioral problems.

Type: Text (1)

Valid Codes	Definition
0-5	Score in the range from 0 to 5
8	Refused
9	Not Completed

Attribute: SDS Score

Transaction:
Co-Occurring Disorders Screening

Definition:
The Substance Disorder Screener (SDS) is designed to identify persons abusing or dependent upon alcohol or other drugs.

Type: Text (1)

Valid Codes	Definition
0-5	Score in the range from 0 to 5
8	Refused
9	Not Completed

Procedure:
- The screening is required for clients 13 and over.
- The screening tool should be scored on self-report only. (If the client is in denial, this will mean a low screening score, even when the client is obviously intoxicated.)
- Only report screenings conducted by your agency.
- The IDS, EDS and SDS score can have a range of 0-5, 8 or 9.
- When reporting the outcome of a screening, a value in each of the scores must be provided. The range for a screening that is completed is between 0 (zero) and 5 in each scale (i.e., IDS, EDS, SDS).
- Use 8 to indicate the client refuses to participate in the specific scale.
- Use 9 to indicate client is unable to complete the specific scale.

Required Documentation:
Providers must document the source of scores. Documentation must include: the date the screening was done and the name, title, and credentials of the clinician who conducted the screening.

Transaction: CPT Service Detail

Definition:
Detailed client service episode records. Since October 16, 2003 this transaction is only used as part of Batch or Extraction error reports from the MHCADSD IS to denote the data were derived from a HIPAA 837P transaction. The fields are listed here to assist with understanding how HIPAA transactions are translated into legacy transactions for processing into the MHCADSD database and how errors are reported to providers in Batch Error reports or Extraction reports.

Required for: Outpatient, Residential, Crisis
The transaction is not accepted for program 101.

Required Documentation:
All services provided to a client must be documented in the clinical record with the date, type, location, and duration of the service episode and the name of the clinician providing the service.

Collection Frequency:
On event

Transaction ID: 120.05

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Service Transaction ID	Text	15	
Event Date	Text (YYYYMMDD)	8	
CPT Code	Text	5	Y
Service Modifier	Text	8	Y
Minutes of Service	Text (number)	4	
Service Location	Text	2	Y
EPSDT Indicator	Text	1	
Staff Person Provider ID	Text	3	Y
Staff Person King County ID	Text	10	
Authorization Number	Text (number)		
King County ID	Text (number)		
Address Line 1	Text	55	N
Address Line 2	Text	55	N
City	Text	30	N
State	Text	2	Y
Zip	Text	15	N
Claim ID	Text	38	N
Primary Service ID	Text	15	N
EBP Code	Text	23	Y

Attribute: *Event Date*

Transaction:
CPT Service Detail

Definition:
The date an episode of service was provided.

Required Documentation:
Providers shall document the date of all service episodes provided.

Type: Date (8)
YYYYMMDD

Attribute: *Service Transaction ID*

Transaction:
CPT Service Detail

Definition:
A number or identifier that uniquely identifies each discrete service event among all service transactions reported by the provider.

Procedure:
- This ID is used to uniquely identify the service record being reported and is generated at the provider level.

Example:
1. A client receives two out of facility case management services on the same day. Each service is reported with a unique service transaction identifier to differentiate the two transactions.

Type: Character (15)

Attribute: CPT Code

Transaction:
CPT Service Detail

Definition:
A Current Procedural Terminology (CPT) or Healthcare Common Procedures Code Set (HCPCS) code that identifies a service delivered to a client.

Procedure:
- All services provided to, or for, a client must be reported.
- Only CPT/HCPCS codes found in the DBHR Service Encounter Reporting Instructions that are available at http://www.dshs.wa.gov/dbhr/sericptinformation.shtml will be accepted unless additional codes are specified by MHCADSD in the King RSN Service Encounter Reporting Instructions contained in Attachment E.
- CPT codes are identified and defined by the American Medical Association (AMA). HCPCS codes are maintained and distributed by the Center for Medicare and Medicaid Services (CMS). Changes may be made to the DBHR and/or King RSN Service Encounter Reporting Instructions as a result of changes made to the CPT codes by the AMA or to the HCPCS codes by CMS.

Required Documentation:
Providers shall maintain documentation in the client's record that supports the service codes submitted.

Attribute: *Service Modifier*

Transaction:
CPT Service Detail

Definition:
A code that indicates a service provided was changed or clarified by some specific circumstance. Modifiers are used in association with Current Procedural Terminology (CPT) and Healthcare Common Procedures Code Set (HCPCS) codes.

Known as Procedure Modifier under HIPAA.

Procedure:
- Enter up to four modifier codes per service encounter.
- Leave the attribute blank if no modifiers are required.
- The CPT (or HCPCS) code/modifier combination must follow the DBHR Service Encounter Reporting Instructions, which are available at http://www.dshs.wa.gov/dbhr/sericptinformation.shtml , and/or the MHCADSD-specific King-RSN Service Encounter Reporting Instructions contained in Attachment E.
- Only modifiers found in the DBHR Service Encounter Reporting Instructions or Attachment E will be accepted.

Examples:
1. HCPCS code H0046 is defined as 'Mental health services, not otherwise specified.' This code in combination with the MHD defined modifier 'UB' identifies an encounter as a 'Request for Service.' Use modifier 'UB' in conjunction with code H0046 to report 'Request for Services' encounters. (See the MHD Service Encounter Reporting Instructions, Request for Services section.)
2. After an intake with a six-year-old girl whose problems include conflicts with other students, the clinician obtains a release of information and contacts her teacher to gain understanding of the girl's school difficulties. Use modifier "UK" in conjunction with code H2015 to report the time spent in collaborative work with the teacher. (See Attachment E, Collateral Contact section.)

Type: Character (8)

Attribute: *Minutes of Service*

Transaction:
CPT Service Detail

Definition:
The number of minutes for a specific Service Event.

Procedure:
- Report the actual minutes (**not** units) unless the service is *per diem*.
- The minutes reported for a service encounter must be between 5 and 1440.
- For per diem services, submit one for minutes of service.

Required Documentation:
Providers shall document the actual number of minutes for each service event (duration) in clinical records.

Type: Number (4)

Attribute: *Service Location*

Transaction:
CPT Service Detail

Definition:
Codes used on professional claims/encounters to specify the place where the service was rendered. HIPAA 837P transactions should use the current code values specified at:
http://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html

Procedure:
- Report one location code for each discrete service event.

Type: Character (2)

Attribute: *EPSDT Indicator*

Transaction:
CPT Service Detail

Definition:
This attribute is used to indicate whether a service: (a) resulted from an Early and Periodic Screening, Diagnosis and Treatment program (EPSDT) screening by a medical provider, or (b) resulted in a referral to a medical provider for an EPSDT screening. EPSDT screenings are required for children (under 21 years of age) who have Medicaid coverage.

Procedure:
- Report a "Y" if this specific service resulted from or led to an EPSDT referral. Otherwise, report "N."

Examples:
1. As a result of an EPSDT screening, a physician refers a six-year-old boy to a mental health center for assessment of mental health treatment needs. The clinician requests an outpatient benefit after the assessment and meets regularly with the boy and/or his father. Submit the assessment service with a "Y" for EPSDT Indicator. Submit subsequent services with "N" for EPSDT Indicator.
2. During an intake for a 12-year-old-girl, the clinician learns that she has not had a physical checkup in three years and refers her to her primary care doctor for an EPSDT screening. Submit the service that led to the referral with a "Y" for EPSDT Indicator. Submit subsequent services with "N" for EPSDT Indicator.

Type: Character (1)

Attribute: *Staff Person Provider ID*

Transaction:
CPT Service Detail

Definition:
This uniquely identifies the agency of the staff person providing the service. This attribute normally is the Reporting Unit ID of the client.

Procedure:
- Where a provider holding an authorization for a benefit has contracted with a second agency to provide services, the authorized provider is responsible for reporting service data, including the second agency staff person providing the service. Use this attribute to report the second agency ID and second agency staff ID.
- For purposes of Interpreter Services, providers using a contracted service bureau may create a single staff ID to represent all bureau staff.

Required Documentation:
All services provided to a client must be documented in the clinical record with the date, type, location and duration of the service episode and the name of the clinician providing the service.

Example:
1. CPC has an authorized client. CPC has contracted with Central Area to provide specific services using Central Area staff. Report the Central Area ID (019) in the Staff Person Provider ID field, and the Central Area staff ID in the Staff ID field.

Type: Text (10)

Attribute: *Staff Person King County ID*

Transaction:
CPT Service Detail

Definition:
This is the King County ID (KCID) for the staff person within an agency who is providing and reporting a service to a client. For services which involve one or more staff persons, the client's primary case manager is the identified staff person, unless the purpose of the service is psychiatric or ARNP consultation. In that instance, the psychiatrist (first) or the ARNP (second) is the identified staff person.

Procedure:
- If the primary case manager is not present, the most senior staff person (determined by education and experience) who is present for the entire service event is the identified staff person.
- For services provided by a consultant or supervisor (e.g., special population consultation), report the KCID of the consultant and not the KCID of the case manager receiving the consultation.
- For consultation modalities where the specialist is a member of the reporting provider staff, the provider must submit the KCID of the consultant.
- When the specialist is either a member of another network provider staff or a mental health specialist on sub-contract with the provider, the provider may report either the provider ID and staff KCID of the specialist, or a staff KCID of "999" indicating that this is a qualified specialist and not a member of the reporting provider staff, or a staff KCID of "998" indicating that this is a special population MH Specialist with one of the special population qualifications listed under the Staff Qualifications transaction.
    - Staff qualifications must be appropriate to the submitted CPT code/modifier(s) combination, as specified in the State MHD Service Encounter Reporting Instructions and/or King RSN Service Encounter Reporting Instructions. To cross-walk MHCADSD staff qualifications to the state's instructions, see the "Mapping-to-State's Provider Type" column in the table for the Qualifications attribute in the Staff Qualifications transaction.

Required Documentation:
All services provided to a client must be documented in the clinical record with the date, type, location (in/out), and duration of the service episode and the name of the clinician providing the service, including the provider staff ID, or the outside specialist's name and staff ID (999).

Type: Text (10)

Attribute: *Address Line 1*

Transaction:
CPT Service Detail

Definition:
Free-form text for the first line of client's mailing address.

Procedure:
- This is a required data element.
- If a client is homeless or client's mailing address is unknown, report the address of agency's office where the letter should be sent.
- This address will be used to send required notification letters to clients.

Required Documentation:
The client's mailing address must be maintained in his/her clinical record.

Type: Text (55)

Attribute: *Address Line 2*

Transaction:
CPT Service Detail

Definition:
Free-form text for the second line of client's mailing address.

Procedure:
- This is an optional data element. It is required only if the mailing address has a second address line.

Required Documentation:
The client's mailing address must be maintained in his/her clinical record.

Type: Text (55)

Attribute: City

Transaction:
CPT Service Detail

Definition:
Free-form text for the city.

Procedure:
- This is a required data element.

Required Documentation:
The client's mailing address must be maintained in his/her clinical record.

Type: Text (30)

Attribute: *State*

Transaction:
CPT Service Detail

Definition:
Official USPS state abbreviation.

Procedure:
- This is a required data element.

Required Documentation:
The client's mailing address must be maintained in his/her clinical record.

Type: Text (2)

Attribute: *Zip code*

Transaction:
CPT Service Detail

Definition:
The five- or nine-digit code for the zip code for the person's latest mailing address.

Procedure:
- This is a required data element.

Required Documentation:
The client's mailing address must be maintained in his/her clinical record.

Type: Text (15)

Attribute: *Claim ID*

Transaction:
CPT Service Detail

Definition:
The submitter's claim identifier from the 837P.

Procedure:
- All services submitted under one Claim ID are considered part of the same encounter if you have identified your system as submitting "one encounter per claim".

Type: Text (38)

Attribute: *Primary Service ID*

Transaction:
CPT Service Detail

Definition:
References the Service ID of the service for which an add-on CPT code has been submitted.

Procedure:
- This is a required data element if you have identified your system as submitting "multiple encounters per claim" and you submit a service that is an add-on CPT code.

Type: Text (17)

Attribute: *EBP Code*

Transaction:
CPT Service Detail

Definition:
Evidenced based practice code.

Procedure:

- This is a pipe-delimited list of valid evidenced based practice codes as outlined in the "Evidence Based Practice – Children's Mental Health" section of the "Service Encounter Reporting Instructions for RSNs" (http://www.dshs.wa.gov/dbhr/sericptinformation.shtml#dbhr).

Type: Text (23)

Transaction: Crisis Diversion Services

Definition: Program specific information for the Crisis Diversion Facility (CDF

Procedure:
- Required for all Crisis Diversion Facility authorizations.

Each Crisis Diversion Facility authorization should have one Crisis Diversion Services record.

Required Documentation:
- Documentation of an interview with the person, referral source, or other informant.
- Attempts at corroboration are desirable and attempts at acquiring corroborating documentation shall be noted in the provider records.

Required for:
Crisis Diversion Facility **(80)**

Frequency:
Each time a person arrives at the Crisis Diversion Facility for services.

Transaction ID: 860.01

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Authorization Number	Text (number)		
Diversion Type	Text	1	Y
Primary Presenting Condition	Text	2	Y
Arrival DateTime	Text (YYYYMMDDHHMM)	12	
Exit DateTime	Text (YYYYMMDDHHMM)	12	
Service Level	Text	3	Y
King County ID	Text (number)		

Attribute: *Diversion Type*

Transaction:
Crisis Diversion Services

Definition:
The Diversion Type is designed to identify the type of facility from which the crisis diversion diverted the person.

Type: Text (1)

Valid Codes	Definition
H	Hospital
J	Jail
N	Neither

Attribute: *Primary Presenting Condition*

Transaction:
Crisis Diversion Services

Definition:
The Primary Presenting Condition describes the perceived current state of the person, at the beginning of a crisis episode, that is a contributing factor to the circumstances leading to the intervention.

Type: Text (2)

Valid Codes	Definition
SA	Substance Abuse
MH	Mental Health
BT	Both

Attribute: *Arrival Start DateTime*

Transaction:
Crisis Diversion Services

Definition:
Indicates the beginning date and time (to the minute) when the individual entered the facility.

Procedure:
- Submit the time in a 24 hour clock format.
- Arrival Start DateTime must be the same day as the Authorization Request Date of Assessment.
- Arrival Start DateTime must precede the Exit DateTime.

Type: DateTime (12)
YYYYMMDDHHMM

Attribute: *Exit DateTime*

Transaction:
Crisis Diversion Services

Definition:
Indicates the date and time (to the minute) at which program services concluded for the individual.

Procedure:
- Submit the time in a 24 hour clock format.
- Exit DateTime must be the same day as the Notice of Exit Event Date (end of the authorization).

Type: DateTime (12)
YYYYMMDDHHMM

Attribute: *Service Level*

Transaction:
Crisis Diversion Services

Definition:
Indicates the intensity of services which the individual received.

Type: Text (3)

Valid Codes	Definition
NAF	Not Appropriate for Facility – individual arrived at facility, did not meet eligibility criteria, provider referred/transferred individual to another service system, agency, or facility
SRL	Stabilization/Referral/Linkage – individual served at facility, provider stabilized/referred/transferred individual to another service system, agency, or facility
ACB	Assigned to a CDF bed

Transaction: Diagnosis

Definition:
Identifies a person's diagnosis.

Required for:
Crisis, Outpatient, Residential, Inpatient

Procedure:

Authorization is in 'UA' status
When an authorization is in 'UA' status, it is important to understand how the MHCADSD system selects the agency-submitted diagnosis transactions to determine if medical necessity has been met and if the GAF/CGAS score qualifies the client for the requested tier.

The system:

1. Selects the client diagnosis records (regardless of authorization number) submitted on the earliest event date between the authorization's assessment date and 92 days into the future.
2. If multiple diagnoses exist for that event date, the one with the highest score is selected. Do not leave an incorrect score or diagnosis in place. Delete the incorrect diagnosis.

Authorization is in 'AA' status
Once an authorization reaches 'AA' status the set of diagnoses with the most recent Event Date on the system is considered applicable. For a given event date, the set of diagnoses should be a complete set of all applicable diagnoses on that date. Resubmit all applicable diagnoses if a diagnosis transaction is submitted for an event date different from the previous event date and previous diagnoses still apply.

Do not delete a diagnostic code unless it was submitted in error. The MHCADSD IS maintains a historical record of all diagnoses for each client.

Frequency:
Initial Assessment
On change to the diagnosis or primary focus
On discharge (or most recent evaluation before discharge) (Axis V only)

Transaction ID: 770.05

Action Codes:

A	Add
C	Change (subtype only)
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Diagnosis Code	Text	5	Y
Event Date	Text (YYYYMMDD)	8	
Diagnosis Axis	Text	1	Y
Axis Subtype	Text	2	Y
Authorization Number	Text (number)		
King County ID	Text (number)		

Attribute: *Diagnosis Code*

Transaction:
Diagnosis

Definition:
- The Diagnosis Code Attribute is used to identify a mental illness or condition, a physical illness or condition, or a psychosocial and/or environmental problem on a diagnostic axis.

Procedure:
- Enter at least one Axis I or Axis II diagnosis, and no more than five Axis I diagnoses and/or two Axis II diagnoses. Diagnosis codes should include substance use disorders.

- Note that for every client, one (and only one) Axis I or Axis II diagnosis must be coded as current focus on a given event date. See the Axis Subtype attribute for further information.

- Subtype is the only field that can be changed on an Axis I or II diagnosis record that has been submitted and posted. If you are changing the primary focus on an existing diagnosis, for an existing event date, change the subtype '01' first to avoid the "DIAGNOSIS IDENTIFIED AS THE PRIMARY FOCUS OF TREATMENT ALREADY EXISTS" error.

- Diagnoses failing one or more of the following edits will be rejected:
  - The diagnosis must be reported in conjunction with the correct Axis code.
  - The diagnosis must be appropriate for the age group of the client
  - **Only International Classification of Diseases codes can be submitted.** For all clients except children under six years old, “The Diagnostic and Statistical Manual (DSM) of Mental Disorders, Fourth Edition, Text Revision” (DSM-IV-TR) diagnoses and diagnostic criteria should be used in the provider medical record and in consultations with MHCADSD staff. For children under six years old, the provider may use a DC03 diagnosis instead of DSM-IV-TR. Use the tables that follow to crosswalk ICD-9-CM codes to DSM-IV-TR codes or to crosswalk DC03 codes to DSM-IV-TR codes.
  - Any diagnosis combination submitted must not be forbidden in ICD-9-CM, DSM-IV-TR, or DC03.
  - No V-codes are permitted.

- Enter the code using the instructions specific to each Axis.

- Agencies must identify the clinician assigning the diagnosis in the face-to-face service record reported to the system and must maintain documentation identifying that clinical staff person by name and title.

- For **Axis I and Axis II**, the individual making the diagnosis can be anyone authorized by the agency to determine diagnosis for these axes.

- No **Axis III** or **Axis IV** data will be accepted.

- For **Axis V**, use the Global Assessment of Functioning **(GAF) Scale score for adults or youth aged 18 years and older**. Use the Children's Global Assessment Scale (**CGAS) for children between the ages of 6 and 17 years**. **Axis V** is not required or accepted **for children under six**. If a client turns 6 during the authorization, start reporting the CGAS when diagnosis data are required. If a client turns 18 during the authorization, switch from reporting the CGAS to the GAF.

  When an authorization is in 'UA' status, the MHCADSD system will select the highest score submitted by an agency, for the client (regardless of authorization number) with an event date greater than or equal to the authorization assessment date up through 92 days after the assessment date. If an error is made, you must *delete* the erroneous diagnosis and resubmit a corrected diagnosis. Do not attempt to change a diagnosis code. It's a component of the key and the change will not take effect.

- For the purpose of coding, use the following code values:
  - **GAF:** precede the score with GA such that the lowest score is coded GA000 and the highest GA100.
  - **CGAS:** precede the score with CG such that the lowest score is coded CG000 and the highest CG100.

- For Axis V on Discharge, where a client is no longer available, submit the GAF or CGAS as determined at the last contact with the client.

- **This is an outcome measure**.

Required Documentation:
Justification for all diagnoses must be provided in agency records. Documentation must include: the date each diagnosis was assigned; the name, title and credentials of the clinician who assigned the diagnosis; and a justification for the diagnosis.

Type: Text (5)

Enter the diagnosis code described below. **Do not enter the decimal**.

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	ICD-9-CM 2002 DEFINITION	ICD-9-CM 2002 CODE	Child	Adult
MENTAL RETARDATION					
317	Mild Mental Retardation	Mild mental retardation	317	*	*
318.0	Moderate Mental Retardation	Moderate mental retardation	318.0	*	*
318.1	Severe Mental Retardation	Severe mental retardation	318.1	*	*
318.2	Profound Mental Retardation	Profound mental retardation	318.2	*	*
319	Mental Retardation, Severity Unspecified	Unspecified mental retardation	319	*	*
LEARNING DISORDERS					
315.00	Reading Disorder	Reading disorder, unspecified	315.00	*	*
315.1	Mathematics Disorder	Mathematics Disorder	315.1	*	*
315.2	Disorder of Written Expression	Other specific learning difficulties	315.2	*	*
315.9	Learning Disorder NOS	Unspecified delay in development	315.9	*	*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	ICD-9-CM 2002 DEFINITION	ICD-9-CM 2002 CODE	Child	Adult
		Specific reading disorder	315.0	*	*
		Alexia	315.01	*	*
		Developmental dyslexia	315.02	*	*
		Specific reading disorder, other	315.09	*	*
MOTOR SKILLS DISORDER					
315.4	Developmental Coordination Disorder	Developmental Coordination Disorder	315.4	*	*
COMMUNICATION DISORDERS					
315.32	Mixed Receptive-Expressive Language Disorder	Mixed Receptive-Expressive Language Disorder	315.32	*	*
315.34	Language and speech development disorder due to hearing loss	Language and speech development disorder due to hearing loss	315.34	*	*
307.0	Stuttering	Stuttering	307.0	*	*
307.9	Communication Disorder NOS	Other and unspecified special symptoms or syndromes, not elsewhere classified	307.9	*	*
		Developmental speech or language disorder	315.3	*	*
PERVASIVE DEVELOPMENTAL DISORDERS					
299.00	Autistic Disorder	Autistic disorder, current or active state	299.00	*	*
299.80	Rett's Disorder	Other specified early childhood psychoses	299.80	*	*
299.10	Childhood Disintegrative Disorder	Childhood disintegrative disorder, current or active state	299.10	*	*
299.80	Asperger's Disorder	Other specified early childhood psychoses	299.80	*	*
299.80	Pervasive Developmental Disorder NOS	Other specified pervasive developmental disorders, current or active state	299.80	*	*
		Autistic disorder, residual state	299.01	*	*
		Infantile autism, unspecified	299.9	*	*
		Mixed developmental disorder	315.5	*	*
		Unspecified delays in development	315.8	*	*
ATTENTION-DEFICIT AND DISRUPTIVE BEHAVIOR DISORDERS					
314.01	Attention-Deficit/Hyperactivity Disorder, Combined type	Attention deficit disorder with hyperactivity	314.01	B	B
314.00	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type	Attention deficit disorder without mention of hyperactivity	314.00	B	B
314.01	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type	Attention deficit disorder with hyperactivity	314.01	B	B
314.9	Attention-Deficit/Hyperactivity Disorder DOS	Unspecified hyperkinetic syndrome	314.9	B	B
312.81	Conduct Disorder, Childhood-Onset Type	Conduct disorder, childhood onset type	312.81	B	*
312.82	Conduct Disorder, Adolescent-Onset Type	Conduct disorder, adolescent onset type	312.82	B	*
312.89	Conduct Disorder, Unspecified Onset	Other conduct disorder	312.89	B	*
313.81	Oppositional Defiant Disorder	Oppositional Defiant Disorder	313.81	B	*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	ICD-9-CM 2002 DEFINITION	ICD-9-CM 2002 CODE	Child	Adult
312.9	Disruptive Behavior Disorder NOS	Unspecified disturbance of conduct	312.9	B	*
		Undersocialized conduct disorder, aggressive type	312.0	*	*
		Undersocialized conduct disorder, aggressive type, unspecified	312.00	*	*
		Undersocialized conduct disorder, aggressive type, mild	312.01	*	*
		Undersocialized conduct disorder, aggressive type, moderate	312.02	*	*
		Undersocialized conduct disorder, aggressive type, severe	312.03	*	*
		Undersocialized conduct disorder, unaggressive type	312.1	*	*
		Undersocialized conduct disorder, unaggressive type, unspecified	312.10	*	*
		Undersocialized conduct disorder, unaggressive type, mild	312.11	*	*
		Undersocialized conduct disorder, unaggressive type, moderate	312.12	*	*
		Undersocialized conduct disorder, unaggressive type, severe	312.13	*	*
		Other specified disturbances of conduct, not elsewhere classified	312.8	*	*
		Attention deficit disorder	314.0	*	*
		Hyperkinesis with developmental delay	314.1	*	*
		Hyperkinetic conduct disorder	314.2	*	*
		Other specified manifestations of hyperkinetic syndrome	314.8	*	*
FEEDING & EATING DISORDERS OF INFANCY OR EARLY CHILDHOOD					
307.52	Pica	Pica	307.52	*	*
307.53	Rumination Disorder	Rumination Disorder	307.53	*	*
307.59	Feeding Disorder or Infancy or Early Childhood	Other disorder of eating	307.59	*	*
		Other and unspecified disorders of eating	307.5	*	*
		Psychogenic vomiting	307.54	*	*
TIC DISORDERS					
307.23	Tourette's Disorder	Tourette's disorder	307.23	*	*
307.22	Chronic Motor or Vocal Tic Disorder	Chronic motor or vocal tic disorder	307.22	*	*
307.21	Transient Tic Disorder	Transient tic disorder	307.21	*	*
307.20	Tic Disorder NOS	Tic disorder, unspecified	307.20	*	*
		Tics	307.2	*	*
ELIMINATION DISORDERS					
787.6	Encopresis With Constipation and Overflow Incontinence	Incontinence of feces	787.6	*	*
307.7	Encopresis Without Constipation and Overflow Incontinence	Encopresis	307.7	*	*
307.6	Enuresis (Not Due to A General Medical Condition)	Enuresis	307.6	*	*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	ICD-9-CM 2002 DEFINITION	ICD-9-CM 2002 CODE	Child	Adult
OTHER DISORDERS OF INFANCY, CHILDHOOD, OR ADOLESCENCE					
309.21	Separation Anxiety Disorder	Separation anxiety disorder	309.21	A	*
313.23	Selective Mutism	Selective Mutism	313.23	B	*
313.89	Reactive Attachment Disorder of Infancy or Early Childhood	Other emotional disturbance of childhood or adolescence	313.89	B	*
307.3	Stereotypical Movement Disorder	Stereotypic movement disorder	307.3	B	*
313.9	Disorder of Infancy, Childhood, or Adolescence NOS	Unspecified emotional disturbance of childhood or adolescence	313.9	B	*
		Sensitivity, shyness, and social withdrawal disorder	313.2	*	*
		Shyness disorder of childhood	313.21	*	*
		Introverted disorder of childhood	313.22	*	*
		Relationship problems	313.3	*	*
		Other or mixed emotional disturbances of childhood or adolescence	313.8	*	*
		Identity disorder	313.82	*	*
		Academic underachievement disorder	313.83	*	*
DELIRIUM, DEMENTIA, AMNESTIC, & OTHER COGNITIVE DISORDERS					
DELIRIUM					
293.0	Delirium Due to... *(Indicate the General Medical Condition)*	Delirium due to conditions classified elsewhere	293.0	*	*
---.--	Substance Intoxication Delirium (*refer to Substance-Related Disorders for substance specific codes)*			*	*
---.--	Substance Withdrawal Delirium (*refer to Substance-Related Disorders for substance-specific codes)*			*	*
---.--	Delirium Due to Multiple Etiologies *(code each of the specific etiologies)*			*	*
780.09	Delirium NOS	Other alteration of consciousness	780.09	*	*
		Subacute delirium	293.1	*	*
DEMENTIA					
294.10	Dementia of the Alzheimer's Type, With Early Onset Without Behavioral Disturbance	Dementia in conditions classified elsewhere without behavioral disturbance	294.10	*	B
294.11	Dementia of the Alzheimer's Type, With Early Onset With Behavioral Disturbance	Dementia in conditions classified elsewhere with behavioral disturbance	294.11	*	B
294.10	Dementia of the Alzheimer's Type, With Late Onset Without Behavioral Disturbance	Dementia in conditions classified elsewhere without behavioral disturbance	294.10	*	B
294.11	Dementia of the Alzheimer's Type, With Late Onset With Behavioral Disturbance	Dementia in conditions classified elsewhere with behavioral disturbance	294.11	*	B
290.40	Vascular Dementia Uncomplicated	Vascular Dementia Uncomplicated	290.40	*	B

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	ICD-9-CM 2002 DEFINITION	ICD-9-CM 2002 CODE	Child	Adult
290.41	Vascular Dementia With Delirium	Vascular Dementia With Delirium	290.41	*	B
290.42	Vascular Dementia With Delusions	Vascular Dementia With Delusions	290.42	*	B
290.43	Vascular Dementia With Depressed Mood	Vascular Dementia With Depressed Mood	290.43	*	B
294.10	Dementia Due to HIV Disease Without Behavioral Disturbance	Dementia in conditions classified elsewhere without behavioral disturbance	294.10	*	B
294.11	Dementia Due to HIV Disease With Behavioral Disturbance	Dementia in conditions classified elsewhere with behavioral disturbance	294.11	8	B
294.10	Dementia Due to Head Trauma Without Behavioral Disturbance	Dementia in conditions classified elsewhere without behavioral disturbance	294.10	*	B
294.11	Dementia Due to Head Trauma With Behavioral Disturbance	Dementia in conditions classified elsewhere with behavioral disturbance	294.11	*	B
294.10	Dementia Due to Parkinson's Disease Without Behavioral Disturbance	Dementia in conditions classified elsewhere without behavioral disturbance	294.10	*	B
294.11	Dementia Due to Parkinson's Disease With Behavioral Disturbance	Dementia in conditions classified elsewhere with behavioral disturbance	294.11	*	B
294.10	Dementia Due to Huntington's Disease Without Behavioral Disturbance	Dementia in conditions classified elsewhere without behavioral disturbance	294.10	*	B
294.11	Dementia Due to Huntington's Disease With Behavioral Disturbance	Dementia in conditions classified elsewhere with behavioral disturbance	294.11	*	B
294.10	Dementia Due to Pick's Disease Without Behavioral Disturbance	Dementia in conditions classified elsewhere without behavioral disturbance	294.10	*	B
294.11	Dementia Due to Pick's Disease With Behavioral Disturbance	Dementia in conditions classified elsewhere with behavioral disturbance	294.11	*	B
294.10	Dementia Due to Creutzfeldt-Jakob Disease Without Behavioral Disturbance	Dementia in conditions classified elsewhere without behavioral disturbance	294.10	*	B
294.11	Dementia Due to Creutzfeldt-Jakob Disease With Behavioral Disturbance	Dementia in conditions classified elsewhere with behavioral disturbance	294.11	*	B
294.10	Dementia Due to... (*Indicate the General Medical Condition not listed above)* Without Behavioral Disturbance	Dementia in conditions classified elsewhere without behavioral disturbance	294.10	*	B
294.11	Dementia Due to... (*Indicate the General Medical Condition not listed above)* With Behavioral Disturbance	Dementia in conditions classified elsewhere with behavioral disturbance	294.11	*	B
---.--	Substance-Induced Persisting Dementia (*refer to Substance-related Disorders for substance specific codes)*			*	B

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	ICD-9-CM 2002 DEFINITION	ICD-9-CM 2002 CODE	Child	Adult
---.--	Dementia Due to Multiple Etiologies			*	B
294.8	Dementia NOS	Other specified organic brain syndromes (chronic)	294.8	*	B
		Senile dementia, uncomplicated	290.0	*	*
		Presenile dementia	290.1	*	*
		Presenile dementia, uncomplicated	290.10	*	*
		Presenile dementia with delirium	290.11	*	*
		Presenile dementia with delusional features	290.12	*	*
		Presenile dementia with depressive features	290.13	*	*
		Senile dementia with delusional or depressive features	290.2	*	*
		Senile dementia with delusional features	290.20	*	*
		Senile dementia with depressive features	290.21	*	*
		Senile dementia with delirium	290.3	*	*
		Unspecified senile psychotic condition	290.9	*	*
AMNESTIC DISORDERS					
294.0	Amnestic Disorder Due to... *(Indicate General Medical Condition)*	Amnestic disorder in conditions classified elsewhere	294.0	*	*
---.--	Substance-Induced Persisting Amnestic Disorder (*refer to Substance-Related Disorders for substance-specific codes)*			*	*
294.8	Amnestic Disorder NOS	Other persistent mental disorders due to conditions classified elsewhere	294.8	*	B
OTHER COGNITIVE DISORDERS					
294.9	Cognitive Disorder NOS	Unspecified persistent mental disorders due to conditions classified elsewhere	294.9	*	B
MENTAL DISORDERS DUE TO A GENERAL MEDICAL CONDITION NOT ELSEWHERE CLASSIFIED					
293.89	Catatonic Disorder Due to... (*Indicate the General Medical Condition)*	Other specified transient mental disorders due to conditions classified elsewhere, other	293.89	*	*
310.1	Personality Change Due to... (*Indicate the General Medical Condition)*	Personality change due to conditions classified elsewhere	310.1	*	*
293.9	Mental Disorder NOS Due to... *(Indicate the General Medical Condition)*	Unspecified transient mental disorders due to conditions classified elsewhere, other	293.9	*	*
		Frontal lobe syndrome	310.0	*	*
		Postconcussion syndrome	310.2	*	*
		Other specified nonpsychotic mental disorders following organic brain damage	310.8	*	*
		Unspecified nonpsychotic mental disorder following organic brain damage	310.9	*	*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	ICD-9-CM 2002 DEFINITION	ICD-9-CM 2002 CODE	Child	Adult
SUBSTANCE-RELATED DISORDERS					
ALCOHOL RELATED DISORDERS					
ALCOHOL USE DISORDERS					
303.90	Alcohol Dependence	Unspecified alcohol dependence	303.90	*	*
305.00	Alcohol Abuse	Unspecified alcohol abuse	305.00	*	*
		Alcohol abuse	305.0	*	*
		Alcohol abuse, continuous	305.01	*	*
		Alcohol abuse, episodic	305.02	*	*
		Alcohol abuse, in remission	305.03	*	*
ALCOHOL-INDUCED DISORDERS					
303.00	Alcohol Intoxication	Acute alcoholic intoxication, unspecified	303.00	*	*
291.81	Alcohol Withdrawal	Alcohol withdrawal	291.81	*	*
291.0	Alcohol Intoxication Delirium	Alcohol withdrawal delirium	291.0	*	*
291.0	Alcohol Withdrawal Delirium	Alcohol withdrawal delirium	291.0	*	*
291.2	Alcohol-Induced Persisting Dementia	Alcohol-Induced Persisting Dementia	291.2	*	*
291.1	Alcohol-Induced Persisting Amnestic Disorder	Alcohol-Induced Persisting Amnestic Disorder	291.1	*	*
291.5	Alcohol-Induced Psychotic Disorder With Delusions	Alcohol-Induced Psychotic Disorder With Delusions	291.5	*	*
291.3	Alcohol-Induced Psychotic Disorder With Hallucinations	Alcohol-Induced Psychotic Disorder With Hallucinations	291.3	*	*
291.89	Alcohol-Induced Mood Disorder	Other specified alcohol-induced mental disorders	291.89	*	*
291.89	Alcohol-Induced Anxiety Disorder	Other specified alcohol-induced mental disorders	291.89	*	*
291.89	Alcohol-Induced Sexual Dysfunction	Other specified alcohol-induced mental disorders	291.89	*	*
291.82	Alcohol-Induced Sleep Disorder	Other specified alcohol-induced mental disorders	291.82	*	*
291.9	Alcohol-Related Disorder NOS	Unspecified alcohol-induced mental disorders	291.9	*	*
		Alcoholic psychoses	291	*	*
		Idiosyncratic alcohol intoxication	291.4	*	*
		Acute alcoholic intoxication	303.0	*	*
		Acute alcoholic intoxication, continuous	303.01	*	*
		Acute alcoholic intoxication, episodic	303.02	*	*
		Acute alcoholic intoxication, in remission	303.03	*	*
		Other and unspecified alcohol dependence	303.9	*	*
AMPHETAMINE (OR AMPHETAMINE-LIKE)-RELATED DISORDERS					
AMPHETAMINE USE DISORDERS					
304.40	Amphetamine Dependence	Unspecified amphetamine and other psychostimulant dependence	304.40	*	*
305.70	Amphetamine Abuse	Unspecified amphetamine and other psychostimulant abuse	305.70	*	*
		Amphetamine and other psychostimulant dependence	304.4	*	*
		Amphetamine or related acting sympathomimetic abuse	305.7	*	*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	ICD-9-CM 2002 DEFINITION	ICD-9-CM 2002 CODE	Child	Adult
		Amphetamine or related acting sympathomimetic abuse, continuous	305.71	*	*
		Amphetamine or related acting sympathomimetic abuse, episodic	305.72	*	*
		Amphetamine or related acting sympathomimetic abuse, in remission	305.73	*	*
AMPHETAMINE-INDUCED DISORDERS					
292.89	Amphetamine Intoxication	Other specified drug-induced mental disorder	292.89	*	*
292.0	Amphetamine Withdrawal	Drug withdrawal	292.0	*	*
292.81	Amphetamine Intoxication Delirium	Drug-induced delirium	292.81	*	*
292.11	Amphetamine-Induced Psychotic Disorder With Delusions	Drug-induced psychotic disorder with delusions	292.11	*	*
292.12	Amphetamine-Induced Psychotic Disorder With Hallucination	Drug-induced psychotic disorder with hallucinations	292.12	*	*
292.84	Amphetamine-Induced Mood Disorder	Drug-induced mood disorder	292.84	*	*
292.89	Amphetamine Induced Sexual Dysfunction	Other specified drug-induced mental disorder	292.89	*	*
292.85	Amphetamine-Induced Sleep Disorder	Other specified drug-induced mental disorder	292.85	*	*
292.9	Amphetamine-Related Disorder NOS	Unspecified drug-induced mental disorder	292.9	*	*
CAFFEINE-RELATED DISORDERS					
CAFFEINE-INDUCED DISORDERS					
305.90	Caffeine Intoxication	Unspecified drug abuse	305.90	*	*
292.89	Caffeine-Induced Anxiety Disorder	Other specified drug-induced mental disorder	292.89	*	*
292.85	Caffeine-Induced Sleep Disorder	Other specified drug-induced mental disorder	292.85	*	*
292.9	Caffeine-Related Disorder NOS	Unspecified drug-induced mental disorder	292.9	*	*
CANNABIS-RELATED DISORDERS					
CANNABIS USE DISORDERS					
304.30	Cannabis Dependence	Unspecified cannabis dependence	304.30	*	*
305.20	Cannabis Abuse	Unspecified cannabis abuse	305.20	*	*
		Cannabis dependence	304.3	*	*
		Cannabis dependence, continuous	304.31	*	*
		Cannabis dependence, episodic	304.32	*	*
		Cannabis dependence, in remission	304.33	*	*
		Cannabis abuse	305.2	*	*
		Cannabis abuse, continuous	305.21	*	*
		Cannabis abuse, episodic	305.22	*	*
		Cannabis abuse, in remission	305.23	*	*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	ICD-9-CM 2002 DEFINITION	ICD-9-CM 2002 CODE	Child	Adult
CANNABIS-INDUCED DISORDERS					
292.89	Cannabis Intoxication	Other specified drug-induced mental disorder	292.89	*	*
292.81	Cannabis Intoxication Delirium	Drug-induced delirium	292.81	*	*
292.11	Cannabis-Induced Psychotic Disorder With Delusions	Drug-induced psychotic disorder with delusions	292.11	*	*
292.12	Cannabis-Induced Psychotic Disorder With Hallucinations	Drug-induced psychotic disorder with hallucinations	292.12	*	*
292.89	Cannabis-Induced Anxiety Disorder	Other specified drug-induced mental disorder	292.89	*	*
292.9	Cannabis-Related Disorder NOS	Unspecified drug-induced mental disorder	292.9	*	*
COCAINE-RELATED DIRORDERS					
COCAINE USE DISORDERS					
304.20	Cocaine Dependence	Unspecified cocaine dependence	304.20	*	*
305.60	Cocaine Abuse	Unspecified cocaine abuse	305.60	*	*
		Cocaine dependence	304.2	*	*
		Cocaine dependence, continuous	304.21	*	*
		Cocaine dependence, episodic	304.22	*	*
		Cocaine dependence, in remission	304.23	*	*
		Cocaine abuse	305.6	*	*
		Cocaine abuse, continuous	305.61	*	*
		Cocaine abuse, episodic	305.62	*	*
		Cocaine abuse, in remission	305.63	*	*
COCAINE-INDUCED DISORDERS					
292.89	Cocaine Intoxication	Other specified drug-induced mental disorder	292.89	*	*
292.0	Cocaine Withdrawal	Drug withdrawal	292.0	*	*
292.81	Cocaine Intoxication Delirium	Drug-induced delirium	292.81	*	*
292.11	Cocaine-Induced Psychotic Disorder With Delusions	Drug-induced psychotic disorder with delusions	292.11	*	*
292.12	Cocaine-Induced Psychotic Disorder With Hallucinations	Drug-induced psychotic disorder with hallucinations	292.12	*	*
292.84	Cocaine-Induced Mood Disorder	Drug-induced mood disorder	292.84	*	*
292.89	Cocaine-Induced Anxiety Disorder	Other specified drug-induced mental disorder	292.89	*	*
292.89	Cocaine-Induced Sexual Dysfunction	Other specified drug-induced mental disorder	292.89	*	*
292.85	Cocaine-Induced Sleep Disorder	Other specified drug-induced mental disorder	292.85	*	*
292.9	Cocaine-Related Disorder NOS	Unspecified drug-induced mental disorder	292.9	*	*
HALLUCINOGEN-RELATED DISORDERS					
HALLUCINOGEN USE DISORDERS					
304.50	Hallucinogen Dependence	Unspecified hallucinogen dependence	304.50	*	*
305.30	Hallucinogen Abuse	Unspecified hallucinogen abuse	305.30	*	*
		Hallucinogen dependence	304.5	*	*
		Hallucinogen abuse	305.3	*	*
		Hallucinogen abuse, continuous	305.31	*	*
		Hallucinogen abuse, episodic	305.32	*	*
		Hallucinogen abuse, in remission	305.33	*	*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	ICD-9-CM 2002 DEFINITION	ICD-9-CM 2002 CODE	Child	Adult
HALLUCINOGEN-INDUCED DISORDERS					
292.89	Hallucinogen Intoxication	Other specified drug-induced mental disorder	292.89	*	*
292.89	Hallucinogen Persisting Perception Disorder (Flashbacks)	Other specified drug-induced mental disorder	292.89	*	*
292.81	Hallucinogen Intoxication Delirium	Drug-induced delirium	292.81	*	*
292.11	Hallucinogen-Induced Psychotic Disorder With Delusions	Drug-induced psychotic disorder with delusions	292.11	*	*
292.12	Hallucinogen-Induced Psychotic Disorder With Hallucinations	Drug-induced psychotic disorder with hallucinations	292.12	*	*
292.84	Hallucinogen-Induced Mood Disorder	Drug-induced mood disorder	292.84	*	*
292.89	Hallucinogen-Induced Anxiety Disorder	Other specified drug-induced mental disorder	292.89	*	*
292.9	Hallucinogen-Related Disorder NOS	Unspecified drug-induced mental disorder	292.9	*	*
INHALANT-RELATED DISORDERS					
INHALANT USE DISORDERS					
304.60	Inhalant Dependence	Unspecified other specified drug dependence	304.60	*	*
305.90	Inhalant Abuse	Unspecified other, mixed, or unspecified drug abuse	305.90	*	*
INHALANT-INDUCED DISORDERS					
292.89	Inhalant Intoxication	Other specified drug-induced mental disorder	292.89	*	*
292.81	Inhalant Intoxication Delirium	Drug-induced delirium	292.81	*	*
292.82	Inhalant-Induced Persisting Dementia	Drug-induced persisting dementia	292.82	*	*
292.11	Inhalant-Induced Psychotic Disorder With Delusions	Drug-induced psychotic disorder with delusions	292.11	*	*
292.12	Inhalant-Induced Psychotic Disorder With Hallucinations	Drug-induced psychotic disorder with hallucinations	292.12	*	*
292.84	Inhalant-Induced Mood Disorder	Drug-induced mood disorder	292.84	*	*
292.89	Inhalant-Induced Anxiety Disorder	Other specified drug-induced mental disorder	292.89	*	*
292.9	Inhalant-Related Disorder NOS	Unspecified drug-induced mental disorder	292.9	*	*
NICOTINE RELATED DISORDERS					
NICOTINE USE DISORDER					
305.1	Nicotine Dependence	Tobacco use disorder	305.1	*	*
		Tobacco use disorder, unspecified	305.10	*	*
		Tobacco use disorder, continuous	305.11	*	*
		Tobacco use disorder, episodic	305.12	*	*
		Tobacco use disorder, in remission	305.13	*	*
NICOTINE-INDUCED DISORDERS					
292.0	Nicotine Withdrawal	Drug withdrawal	292.0	*	*
292.9	Nicotine-Related Disorder NOS	Unspecified drug-induced mental disorder	292.9	*	*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	ICD-9-CM 2002 DEFINITION	ICD-9-CM 2002 CODE	Child	Adult
OPIOID-RELATED DISORDERS					
OPIOID USE DISORDERS					
304.00	Opioid Dependence	Unspec. opioid type dependence	304.00	*	*
305.50	Opioid Abuse	Unspecified opioid abuse	305.50	*	*
		Opioid type dependence	304.0	*	*
		Opioid type dependence, continuous	304.01	*	*
		Opioid type dependence, episodic	304.02	*	*
		Opioid type dependence, in remission	304.03	*	*
		Opioid abuse	305.5	*	*
		Opioid abuse, continuous	305.51	*	*
		Opioid abuse, episodic	305.52	*	*
		Opioid abuse, in remission	305.53	*	*
OPIOID-INDUCED DISORDERS					
292.89	Opioid Intoxication	Other specified drug-induced mental disorder	292.89	*	*
292.0	Opioid Withdrawal	Drug withdrawal	292.0	*	*
292.81	Opioid Intoxication Delirium	Drug-induced delirium	292.81	*	*
292.11	Opioid-Induced Psychotic Disorder With Delusions	Drug-induced psychotic disorder with delusions	292.11	*	*
292.12	Opioid-Induced Psychotic Disorder With Hallucinations	Drug-induced psychotic disorder with hallucinations	292.12	*	*
292.84	Opioid-Induced Mood Disorder	Drug-induced mood disorder	292.84	*	*
292.89	Opioid-Induced Sexual Dysfunction	Other specified drug-induced mental disorder	292.89	*	*
292.85	Opioid-Induced Sleep Disorder	Other specified drug-induced mental disorder	292.85	*	*
292.9	Opioid-Related Disorder NOS	Unspecified drug-induced mental disorder	292.9	*	*
PHENCYCLIDINE (OR PHENCYCLIDINE-LIKE)-RELATED DISORDERS					
PHENCYCLIDINE USE DISORDERS					
304.60	Phencyclidine Dependence	Unspecified other specified drug dependence	304.60	*	*
305.90	Phencyclidine Abuse	Unspecified other, mixed, or unspecified drug abuse	305.90	*	*
PHENCYCLIDINE-INDUCED DISORDERS					
292.89	Phencyclidine Intoxication	Other specified drug-induced mental disorder	292.89	*	*
292.81	Phencyclidine Intoxication Delirium	Drug-induced delirium	292.81	*	*
292.11	Phencyclidine-Induced Psychotic Disorder With Delusions	Drug-induced psychotic disorder with delusions	292.11	*	*
292.12	Phencyclidine-Induced Psychotic Disorder With Hallucinations	Drug-induced psychotic disorder with hallucinations	292.12	*	*
292.84	Phencyclidine-Induced Mood Disorder	Drug-induced mood disorder	292.84	*	*
292.89	Phencyclidine-Induced Anxiety Disorder	Other specified drug-induced mental disorder	292.89	*	*
292.9	Phencyclidine-Related Disorder NOS	Unspecified drug-induced mental disorder	292.9	*	*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	ICD-9-CM 2002 DEFINITION	ICD-9-CM 2002 CODE	Child	Adult
SEDATIVE-, HYPNOTIC-, OR ANXIOLYTIC-RELATED DIRORDERS					
SEDATIVE, HYPNOTIC, OR ANXIOLYTIC USE DISORDERS					
304.10	Sedative, Hypnotic, or Anxiolytic Dependence	Sedative, Hypnotic, or Anxiolytic Dependence, unspecified	304.10	*	*
305.40	Sedative, Hypnotic, or Anxiolytic Abuse	Unspecified barbiturate and similarly acting sedative or hypnotic abuse	305.40	*	*
		Barbiturate and similarly acting sedative or hypnotic dependence	304.1	*	*
		Sedative, Hypnotic, or Anxiolytic Dependence, continuous	304.11	*	*
		Sedative, Hypnotic, or Anxiolytic Dependence, episodic	304.12	*	*
		Sedative, Hypnotic, or Anxiolytic Dependence, in remission	304.13	*	*
		Sedative, hypnotic or anxiolytic abuse, unspecified	305.4	*	*
		Sedative, hypnotic or anxiolytic abuse, continuous	305.41	*	*
		Sedative, hypnotic or anxiolytic abuse, episodic	305.42	*	*
		Sedative, hypnotic or anxiolytic abuse, in remission	305.43	*	*
SEDATIVE-, HYPNOTIC-, OR ANXIOLYTIC-INDUCED DISORDERS					
292.89	Sedative, Hypnotic or Anxiolytic Intoxication	Other specified drug-induced mental disorder	292.89	*	*
292.0	Sedative, Hypnotic or Anxiolytic Withdrawal	Drug withdrawal	292.0	*	*
292.81	Sedative, Hypnotic or Anxiolytic Intoxication Delirium	Drug-induced delirium	292.81	*	*
292.81	Sedative, Hypnotic or Anxiolytic Withdrawal Delirium	Drug-induced delirium	292.81	*	*
292.82	Sedative, Hypnotic or Anxiolytic-Induced Persisting Dementia	Drug-induced persisting dementia	292.82	*	*
292.83	Sedative, Hypnotic or Anxiolytic-Induced Persisting Amnestic Disorder	Drug-induced persisting amnestic disorder	292.83	*	*
292.11	Sedative, Hypnotic or Anxiolytic-Induced Psychotic Disorder With Delusions	Drug-induced psychotic disorder with delusions	292.11	*	*
292.12	Sedative, Hypnotic or Anxiolytic-Induced Psychotic Disorder With Hallucinations	Drug-induced psychotic disorder with hallucinations	292.12	*	*
292.84	Sedative, Hypnotic or Anxiolytic-Induced Mood Disorder	Drug-induced mood disorder	292.84	*	*
292.89	Sedative, Hypnotic or Anxiolytic-Induced Anxiety Disorder	Other specified drug-induced mental disorder	292.89	*	*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	ICD-9-CM 2002 DEFINITION	ICD-9-CM 2002 CODE	Child	Adult
292.89	Sedative, Hypnotic or Anxiolytic-Induced Sexual Dysfunction	Other specified drug-induced mental disorder	292.89	*	*
292.85	Sedative, Hypnotic or Anxiolytic-Induced Sleep Disorder	Other specified drug-induced mental disorder	292.85	*	*
292.9	Sedative, Hypnotic or Anxiolytic-Related Disorder NOS	Unspecified drug-induced mental disorder	292.9	*	*
POLYSUBSTANCE-RELATED DISORDER					
304.80	Polysubstance Dependence	Unspecified combinations of drug dependence excluding opioid type drug	304.80	*	*
		Combinations of opioid type drug with any other	304.7	*	*
		Combinations of drug dependence excluding opioid type drug	304.8	*	*
OTHER (OR UNKNOWN) SUBSTANCE-RELATED DISORDER					
OTHER (OR UNKNOWN) SUBSTANCE USE DISORDERS					
304.90	Other (or Unknown) Substance Dependence	Unspecified drug dependence	304.90	*	*
305.90	Other (or Unknown) Substance Abuse	Unspecified other, mixed, or unspecified drug abuse	305.90	*	*
		Unspecified drug dependence	304.9	*	*
OTHER (OR UNKNOWN) SUBSTANCE-INDUCED DISORDERS					
292.89	Other (or Unknown) Substance Intoxication	Other specified drug-induced mental disorder	292.89	*	*
292.0	Other (or Unknown) Substance Withdrawal	Drug withdrawal	292.0	*	*
292.81	Other (or Unknown) Substance-Induced Delirium	Drug-induced delirium	292.81	*	*
292.82	Other (or Unknown) Substance-Induced Persisting Dementia	Drug-induced persisting dementia	292.82	*	*
292.83	Other (or Unknown) Substance-Induced Persisting Amnestic Disorder	Drug-induced persisting amnestic disorder	292.83	*	*
292.11	Other (or Unknown) Substance-Induced Psychotic Disorder With Delusions	Drug-induced psychotic disorder with delusions	292.11	*	*
292.12	Other (or Unknown) Substance-Induced Psychotic Disorder With Hallucinations	Drug-induced psychotic disorder with hallucinations	292.12	*	*
292.84	Other (or Unknown) Substance-Induced Mood Disorder	Drug-induced mood disorder	292.84	*	*
292.89	Other (or Unknown) Substance-Induced Anxiety Disorder	Other specified drug-induced mental disorder	292.89	*	*
292.89	Other (or Unknown) Substance-Induced Sexual Dysfunction	Other specified drug-induced mental disorder	292.89	*	*
292.85	Other (or Unknown) Substance-Induced Sleep Disorder	Other specified drug-induced mental disorder	292.85	*	*
292.9	Other (or Unknown) Substance-Related Disorder NOS	Unspecified drug-induced mental disorder	292.9	*	*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	ICD-9-CM 2002 DEFINITION	ICD-9-CM 2002 CODE	Child	Adult
		Paranoid and/or hallucinatory states induced by drugs	292.1	*	*
		Pathological drug intoxication	292.2	*	*
		Antidepressant type abuse	305.8	*	*
		Other, mixed, or unspecified drug abuse	305.9	*	*
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS					
295.30	Schizophrenia Paranoid Type	Schizophrenic disorder, paranoid type, unspecified	295.30	A	A
295.10	Schizophrenia Disorganized Type	Schizophrenic disorder, disorganized type, unspecified	295.10	A	A
295.20	Schizophrenia Catatonic Type	Schizophrenic disorder, catatonic type, unspecified	295.20	A	A
295.90	Schizophrenia Undifferentiated Type	Schizophrenic disorder, unspecified, unspecified	295.90	A	A
295.60	Schizophrenia Residual Type	Schizophrenic disorder, residual type, unspecified	295.60	A	A
295.40	Schizophreniform Disorder	Schizophreniform Disorder, unspecified	295.40	A	A
295.70	Schizoaffective Disorder	Schizoaffective Disorder, unspecified	295.70	A	A
297.1	Delusional Disorder	Delusional disorder	297.1	A	A
298.8	Brief Psychotic Disorder	Other and unspecified reactive psychosis	298.8	A	A
297.3	Shared Psychotic Disorder	Shared psychotic disorder	297.3	A	A
293.81	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Delusions	Psychotic disorder with delusions in conditions classified elsewhere	293.81	A	A
293.82	Psychotic Disorder Due to *(Indicate the General Medical Condition)* With Hallucinations	Psychotic disorder with hallucinations in conditions classified elsewhere	293.82	A	A
---.--	Substance-Induced Psychotic Disorder			*	*
298.9	Psychotic Disorder NOS	Unspecified psychosis	298.9	A	A
		Schizophrenic disorder, simple type, unspecified	295.00	*	*
		Schizophrenic disorder, simple type, subchronic	295.01	*	*
		Schizophrenic disorder, simple type, chronic	295.02	*	*
		Schizophrenic disorder, simple type, subchronic with acute exacerbation	295.03	*	*
		Schizophrenic disorder, simple type, chronic with acute exacerbation	295.04	*	*
		Schizophrenic disorder, simple type, in remission	295.05	*	*
		Schizophrenic disorder, disorganized type, subchronic	295.11	*	*
		Schizophrenic disorder, disorganized type, chronic	295.12	*	*
		Schizophrenic disorder, disorganized type, subchronic with acute exacerbation	295.13	*	*
		Schizophrenic disorder, disorganized type, chronic with acute exacerbation	295.14	*	*
		Schizophrenic disorder, disorganized type, in remission	295.15	*	*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	ICD-9-CM 2002 DEFINITION	ICD-9-CM 2002 CODE	Child	Adult
		Schizophrenic disorder, catatonic type, subchronic	295.21	*	*
		Schizophrenic disorder, catatonic type, chronic	295.22	*	*
		Schizophrenic disorder, catatonic type, subchronic with acute exacerbation	295.23	*	*
		Schizophrenic disorder, catatonic type, chronic with acute exacerbation	295.24	*	*
		Schizophrenic disorder, catatonic type, in remission	295.25	*	*
		Schizophrenic disorder, paranoid type, subchronic	295.31	*	*
		Schizophrenic disorder, paranoid type, chronic	295.32	*	*
		Schizophrenic disorder, paranoid type, subchronic with acute exacerbation	295.33	*	*
		Schizophrenic disorder, paranoid type, chronic with acute exacerbation	295.34	*	*
		Schizophrenic disorder, paranoid type, in remission	295.35	*	*
		Schizophrenic disorder, latent schizophrenia, unspecified	295.50	*	*
		Schizophrenic disorder, latent schizophrenia, subchronic	295.51	*	*
		Schizophrenic disorder, latent schizophrenia, chronic	295.52	*	*
		Schizophrenic disorder, latent schizophrenia, subchronic with acute exacerbation	295.53	*	*
		Schizophrenic disorder, latent schizophrenia, chronic with acute exacerbation	295.54	*	*
		Schizophrenic disorder, latent schizophrenia, in remission	295.55	*	*
		Schizophrenic disorder, residual type, subchronic	295.61	*	*
		Schizophrenic disorder, residual type, chronic	295.62	*	*
		Schizophrenic disorder, residual type, subchronic with acute exacerbation	295.63	*	*
		Schizophrenic disorder, residual type, chronic with acute exacerbation	295.64	*	*
		Schizophrenic disorder, residual type, in remission	295.65	*	*
		Schizoaffective Disorder, subchronic	295.71	*	*
		Schizoaffective Disorder, chronic	295.72	*	*
		Schizoaffective Disorder, subchronic with acute exacerbation	295.73	*	*
		Schizoaffective Disorder, chronic with acute exacerbation	295.74	*	*
		Schizoaffective Disorder, in remission	295.75	*	*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	ICD-9-CM 2002 DEFINITION	ICD-9-CM 2002 CODE	Child	Adult
		Schizophrenic disorder, other specified types of schizophrenia, unspecified	295.80	*	*
		Schizophrenic disorder, other specified types of schizophrenia, subchronic	295.81	*	*
		Schizophrenic disorder, other specified types of schizophrenia, chronic	295.82	*	*
		Schizophrenic disorder, other specified types of schizophrenia, subchronic with acute exacerbation	295.83	*	*
		Schizophrenic disorder, other specified types of schizophrenia, chronic with acute exacerbation	295.84	*	*
		Schizophrenic disorder, other specified types of schizophrenia, in remission	295.85	*	*
		Schizophrenic disorder, unspecified, subchronic	295.91	*	*
		Schizophrenic disorder, unspecified, chronic	295.92	*	*
		Schizophrenic disorder, unspecified, subchronic with acute exacerbation	295.93	*	*
		Schizophrenic disorder, unspecified, chronic with acute exacerbation	295.94	*	*
		Schizophrenic disorder, unspecified, in remission	295.95	*	*
		Paranoid state, simple	297.0	*	*
		Paraphrenia	297.2	*	*
		Other specified paranoid states	297.8	*	*
		Unspecified paranoid state	297.9	*	*
		Depressive type psychosis	298.0	*	*
		Excitative type psychosis	298.1	*	*
		Reactive confusion	298.2	*	*
		Acute paranoid reaction	298.3	*	*
		Psychogenic paranoid psychosis	298.4	*	*
MOOD DISORDERS					
DEPRESSIVE DISORDERS					
296.21	Major Depressive Disorder Single Episode, Mild	Major depressive disorder, single episode, mild	296.21	*	A
296.22	Major Depressive Disorder Single Episode, Moderate	Major depressive disorder, single episode, moderate	296.22	A	A
296.23	Major Depressive Disorder Single Episode, Severe Without Psychotic Features	Major depressive disorder, single episode, severe, without mention of psychotic behavior	296.23	A	A
296.24	Major Depressive Disorder Single Episode, Severe With Psychotic Features	Major depressive disorder, single episode, severe, specified as with psychotic behavior	296.24	A	A
296.25	Major Depressive Disorder Single Episode, In Partial Remission	Major depressive disorder, single episode, in partial or unspecified remission	296.25	A	A
296.26	Major Depressive Disorder Single Episode, In Full Remission	Major depressive disorder, single episode, in full remission	296.26	A	A

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	ICD-9-CM 2002 DEFINITION	ICD-9-CM 2002 CODE	Child	Adult
296.20	Major Depressive Disorder Single Episode, Unspecified	Major depressive disorder, single episode, unspecified	296.20	A	A
296.31	Major Depressive Disorder Recurrent, Mild	Major depressive disorder, recurrent episode, mild	296.31	A	A
296.32	Major Depressive Disorder Recurrent, Moderate	Major depressive disorder, recurrent episode, moderate	296.32	A	A
296.33	Major Depressive Disorder Recurrent, Severe Without Psychotic Features	Major depressive disorder, recurrent episode, severe, without mention of psychotic behavior	296.33	A	A
296.34	Major Depressive Disorder Recurrent, Severe With Psychotic Features	Major depressive disorder, recurrent episode, severe, specified as with psychotic behavior	296.34	A	A
296.35	Major Depressive Disorder Recurrent, In Partial Remission	Major depressive disorder, recurrent episode, in partial or unspecified remission	296.35	A	A
296.36	Major Depressive Disorder Recurrent, In Full Remission	Major depressive disorder, recurrent episode, in full remission	296.36	A	A
296.30	Major Depressive Disorder Recurrent, Unspecified	Major depressive disorder, recurrent episode, unspecified	296.30	A	A
300.4	Dysthymic Disorder	Dysthymic Disorder	300.4	A	B
311	Depressive Disorder	Depressive disorder, not elsewhere classified	311	A	B
BIPOLAR DISORDERS					
296.01	Bipolar I Disorder Single Manic Episode, Mild	Bipolar I Disorder Single Manic Episode, Mild	296.01	A	A
296.02	Bipolar I Disorder Single Manic Episode, Moderate	Bipolar I Disorder Single Manic Episode, moderate	296.02	A	A
296.03	Bipolar I Disorder Single Manic Episode, Severe Without Psychotic Features	Bipolar I Disorder Single Manic Episode, severe, without mention of psychotic behavior	296.03	A	A
296.04	Bipolar I Disorder Single Manic Episode, Severe With Psychotic Features	Bipolar I Disorder Single Manic Episode severe, specified as with psychotic behavior	296.04	A	A
296.05	Bipolar I Disorder Single Manic Episode, In Partial Remission	Bipolar I Disorder Single Manic Episode, in partial or unspecified remission	296.05	A	A
296.06	Bipolar I Disorder Single Manic Episode, In Full Remission	Bipolar I Disorder Single Manic Episode, in full remission	296.06	A	A
296.00	Bipolar I Disorder Single Manic Episode, Unspecified	Bipolar I Disorder Single Manic Episode, Unspecified	296.00	A	A
296.40	Bipolar I Disorder Most Recent Episode Hypomanic	Bipolar I disorder, most recent episode (or current) manic, unspecified	296.40	A	A
296.41	Bipolar I Disorder Most Recent Episode Manic, Mild	Bipolar I disorder, most recent episode (or current) manic, mild	296.41	A	A
296.42	Bipolar I Disorder Most Recent Episode Manic, Moderate	Bipolar I disorder, most recent episode (or current) manic, moderate	296.42	A	A
296.43	Bipolar I Disorder Most Recent Episode Manic, Severe Without Psychotic Features	Bipolar I disorder, most recent episode (or current) manic, severe, without mention of psychotic behavior	296.43	A	A

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	ICD-9-CM 2002 DEFINITION	ICD-9-CM 2002 CODE	Child	Adult
296.44	Bipolar I Disorder Most Recent Episode Manic, Severe With Psychotic Features	Bipolar I disorder, most recent episode (or current) manic, severe, specified as with psychotic behavior	296.44	A	A
296.45	Bipolar I Disorder Most Recent Episode Manic, In Partial Remission	Bipolar I disorder, most recent episode (or current) manic, in partial or unspecified remission	296.45	A	A
296.46	Bipolar I Disorder Most Recent Episode Manic, In Full Remission	Bipolar I disorder, most recent episode (or current) manic, in full remission	296.46	A	A
296.40	Bipolar I Disorder Most Recent Episode Manic, Unspecified	Bipolar affective disorder, manic, unspecified	296.40	A	A
296.61	Bipolar I Disorder Most Recent Episode Mixed, Mild	Bipolar I disorder, most recent episode (or current) mixed, mild	296.61	A	A
296.62	Bipolar I Disorder Most Recent Episode Mixed, Moderate	Bipolar I disorder, most recent episode (or current) mixed, moderate	296.62	A	A
296.63	Bipolar I Disorder Most Recent Episode Mixed, Severe Without Psychotic Features	Bipolar I disorder, most recent episode (or current) mixed, severe, without mention of psychotic behavior	296.63	A	A
296.64	Bipolar I Disorder Most Recent Episode Mixed, Severe With Psychotic Features	Bipolar I disorder, most recent episode (or current) mixed, severe, specified as with psychotic behavior	296.64	A	A
296.65	Bipolar I Disorder Most Recent Episode Mixed, In Partial Remission	Bipolar I disorder, most recent episode (or current) mixed, in partial or unspecified remission	296.65	A	A
296.66	Bipolar I Disorder Most Recent Episode Mixed, In Full Remission	Bipolar I disorder, most recent episode (or current) mixed, in full remission	296.66	A	A
296.60	Bipolar I Disorder Most Recent Episode Mixed, Unspecified	Bipolar I disorder, most recent episode (or current) mixed, unspecified	296.60	A	A
296.51	Bipolar I Disorder Most Recent Episode Depressed, Mild	Bipolar I disorder, most recent episode (or current) depressed, mild	296.51	A	A
296.52	Bipolar I Disorder Most Recent Episode Depressed, Moderate	Bipolar I disorder, most recent episode (or current) depressed, moderate	296.52	A	A
296.53	Bipolar I Disorder Most Recent Episode Depressed, Severe Without Psychotic Features	Bipolar I disorder, most recent episode (or current) depressed, severe, without mention of psychotic behavior	296.53	A	A
296.54	Bipolar I Disorder Most Recent Episode Depressed, Severe With Psychotic Features	Bipolar I disorder, most recent episode (or current) depressed, severe, specified as with psychotic behavior	296.54	A	A
296.55	Bipolar I Disorder Most Recent Episode Depressed, In Partial Remission	Bipolar I disorder, most recent episode (or current) depressed, in partial or unspecified remission	296.55	A	A
296.56	Bipolar I Disorder Most Recent Episode Depressed, In Full Remission	Bipolar I disorder, most recent episode (or current) depressed, in full remission	296.56	A	A
296.50	Bipolar I Disorder Most Recent Episode Depressed, Unspecified	Bipolar I disorder, most recent episode (or current) depressed, unspecified	296.50	A	A
296.7	Bipolar I Disorder Most Recent Episode Unspecified	Bipolar I disorder, most recent episode (or current) unspecified	296.7	A	A
296.89	Bipolar II Disorder	Other and unspecified bipolar disorders, other	296.89	A	A
301.13	Cyclothymic Disorder	Cyclothymic disorder	301.13	B	B

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	ICD-9-CM 2002 DEFINITION	ICD-9-CM 2002 CODE	Child	Adult
296.80	Bipolar Disorder NOS	Bipolar disorder, unspecified	296.80	A	A
293.83	Mood Disorder Due to...*(Indicate the General Medical Condition)*	Mood disorder in conditions classified elsewhere	293.83	*	*
---.--	Substance Induced Mood Disorder *(refer to Substance-Related Disorders for substance-specific codes)*			*	*
296.90	Mood Disorder NOS	Unspecified episodic mood disorder	296.90	A	B
		Manic disorder, recurrent episode, unspecified	296.10	*	*
		Manic disorder, recurrent episode, mild	296.11	*	*
		Manic disorder, recurrent episode, moderate	296.12	*	*
		Manic disorder, recurrent episode, severe, without mention of psychotic behavior	296.13	*	*
		Manic disorder, recurrent episode, severe, specified as with psychotic behavior	296.14	*	*
		Manic disorder, recurrent episode, in partial or unspecified remission	296.15	*	*
		Manic disorder, recurrent episode, in full remission	296.16	*	*
		Atypical manic disorder	296.81	*	*
		Atypical depressive disorder	296.82	*	*
		Other specified affective psychoses	296.99	*	*
ANXIETY DISORDERS					
300.01	Panic Disorder Without Agoraphobia	Panic disorder without agoraphobia	300.01	A	B
300.21	Panic Disorder With Agoraphobia	Agoraphobia with panic disorder	300.21	A	B
300.22	Agoraphobia Without History of Panic Disorder	Agoraphobia without mention of panic attacks	300.22	A	B
300.29	Specific Phobia	Other isolated or specific phobias	300.29	B	B
300.23	Social Phobia	Social phobia	300.23	B	B
300.3	Obsessive-Compulsive Disorder	Obsessive-compulsive disorder	300.3	A	B
309.81	Posttraumatic Stress Disorder	Posttraumatic Stress Disorder	309.81	A	A
308.3	Acute Stress Disorder	Other acute reactions to stress	308.3	A	A
300.02	Generalized Anxiety Disorder	Generalized anxiety disorder	300.02	A	B
293.84	Anxiety Disorder Due to...*(Indicate the General Medical Condition)*	Anxiety disorder in conditions classified elsewhere	293.84	*	*
---.--	Substance-Induced Anxiety Disorder (*refer to Substance-Related Disorders for substance specific codes)*			*	*
300.00	Anxiety Disorder NOS	Anxiety state, unspecified	300.00	A	B
		Anxiety state, other	300.09	*	*
		Phobia, unspecified	300.20	*	*
		Neurasthenia	300.5	*	*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	ICD-9-CM 2002 DEFINITION	ICD-9-CM 2002 CODE	Child	Adult
		Acute reaction to stress, predominant disturbance of emotion	308.0	*	*
		Acute reaction to stress, predominant disturbance of consciousness	308.1	*	*
		Acute reaction to stress, predominant psychomotor disturbance	308.2	*	*
		Acute reaction to stress, mixed disorders as reaction to stress	308.4	*	*
		Acute reaction to stress, unspecified acute reaction to stress	308.9	*	*
SOMATOFORM DISORDERS					
300.81	Somatization Disorder	Somatization disorder	300.81	B	B
300.82	Undifferentiated Somatoform Disorder	Undifferentiated somatoform disorder	300.82	B	B
300.11	Conversion Disorder	Conversion disorder	300.11	B	B
307.80	Pain Disorder Associated With Psychological Factors	Psychogenic pain, site unspecified	307.80	B	B
307.89	Pain Disorder Associated With Both Psychological Factors and a General Medical Condition	Other pain disorder related to psychological factors	307.89	B	B
300.7	Hypochondriasis	Hypochondriasis	300.7	B	B
300.7	Body Dysmorphic Disorder	Hypochondriasis	300.7	B	B
300.82	Somatoform Disorder NOS	Undifferentiated somatoform disorder	300.82	B	B
		Hysteria, unspecified	300.10	*	*
		Physiological malfunction arising from mental factors, musculoskeletal	306.0	*	*
		Physiological malfunction arising from mental factors, respiratory	306.1	*	*
		Physiological malfunction arising from mental factors, cardiovascular	306.2	*	*
		Physiological malfunction arising from mental factors, skin	306.3	*	*
		Physiological malfunction arising from mental factors, gastrointestinal	306.4	*	*
		Physiological malfunction arising from mental factors, genitourinary	306.5	*	*
		Psychogenic genitourinary	306.50	*	*
		Psychogenic dysmenorrhea	306.52	*	*
		Psychogenic dysuria	306.53	*	*
		Physiological malfunction arising from mental factors, genitourinary, other	306.59	*	*
		Physiological malfunction arising from mental factors, endocrine	306.6	*	*
		Physiological malfunction arising from mental factors, organs of special sense	306.7	*	*
		Physiological malfunction arising from mental factors, other specified psychophysiological malfunction	306.8	*	*
		Physiological malfunction arising from mental factors, unspecified	306.9	*	*
		Psychalgia	307.8	*	*
		Tension headaches	307.81	*	*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	ICD-9-CM 2002 DEFINITION	ICD-9-CM 2002 CODE	Child	Adult
FACTITIOUS DISORDERS					
300.16	Factitious Disorder With Predominantly Psychological Signs and Symptoms	Factitious Disorder With Predominantly Psychological Signs and Symptoms	300.16	B	B
300.19	Factitious Disorder With Predominantly Physical Signs and Symptoms	Other and unspecified factitious illness	300.19	B	B
300.19	Factitious Disorder With Combined Psychological and Physical Signs and Symptoms	Other and unspecified factitious illness	300.19	B	B
300.19	Factitious Disorder NOS	Other and unspecified factitious illness	300.19	B	B
		Chronic factitious illness with physical symptoms	301.51	*	*
DISSOCIATIVE DISORDERS					
300.12	Dissociative Amnesia	Dissociative Amnesia	300.12	B	B
300.13	Dissociative Fugue	Dissociative Fugue	300.13	B	B
300.14	Dissociative Identity Disorder	Dissociative Identity Disorder	300.14	B	B
300.6	Depersonalization Disorder	Depersonalization Disorder	300.6	B	B
300.15	Dissociative Disorder NOS	Dissociative disorder or reaction, unspecified	300.15	B	B
SEXUAL AND GENDER IDENTITY DISORDERS					
SEXUAL DYSFUNCTIONS					
SEXUAL DESIRE DISORDERS					
302.71	Hypoactive Sexual Desire Disorder	Hypoactive Sexual Desire Disorder	302.71	*	*
302.79	Sexual Aversion Disorder	Psychosexual dysfunction with other specified psychosexual dysfunctions	302.79	*	*
SEXUAL AROUSAL DISORDERS					
302.72	Female Sexual Arousal Disorder	Psychosexual dysfunction with inhibited sexual excitement	302.72	*	*
302.72	Male Erectile Disorder	Psychosexual dysfunction with inhibited sexual excitement	302.72	*	*
ORGASMIC DISORDERS					
302.73	Female Orgasmic Disorder	Female Orgasmic Disorder	302.73	*	*
302.74	Male Orgasmic Disorder	Male Orgasmic Disorder	302.74	*	*
302.75	Premature Ejaculation	Premature ejaculation	302.75	*	*
SEXUAL PAIN DISORDERS					
302.76	Dyspareunia (Not Due to a General Medical Condition)	Dyspareunia, psychogenic	302.76	*	*
306.51	Vaginismus (Not Due to a General Medical Condition)	Psychogenic vaginismus	306.51	*	*
SEXUAL DYSFUNCTION DUE TO A GENERAL MEDICAL CONDITION					
625.8	Female Hypoactive Sexual Desire Disorder Due to ... (*Indicate the General Medical Condition)*	Other specified symptoms associated with female genital organs	625.8	*	*
608.89	Male Hypoactive Sexual Desire Disorder Due to... (*Indicate the General Medical Condition)*	Other specified disorders of male genital organs, other	608.89	*	*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	ICD-9-CM 2002 DEFINITION	ICD-9-CM 2002 CODE	Child	Adult
607.84	Male Erectile Disorder Due to ... (*Indicate the General Medical Condition)*	Impotence of organic origin	607.84	*	*
625.0	Female Dyspareunia Due to... (*Indicate the General Medical Condition)*	Dyspareunia	625.0	*	*
608.89	Male Dyspareunia Due to... *(Indicate the General Medical Condition)*	Other specified disorders of male genital organs, other	608.89	*	*
625.8	Other Female Sexual Dysfunction Due to... (*Indicate the General Medical Condition)*	Other specified symptoms associated with female genital organs	625.8	*	*
608.89	Other Male Sexual Dysfunction Due to... *(Indicate the General Medical Condition)*	Other specified disorders of male genital organs, other	608.89	*	*
---.--	Substance-Induced Sexual Dysfunction (*refer to Substance –Related Disorders for substance specific codes)*			*	*
302.70	Sexual Dysfunction NOS	Psychosexual dysfunction, unspecified	302.70	*	*
PARAPHILIAS					
302.4	Exhibitionism	Exhibitionism	302.4	*	*
302.81	Fetishism	Fetishism	302.81	*	*
302.89	Frotteurism	Other specified psychosexual disorder	302.89	*	*
302.2	Pedophilia	Pedophilia	302.2	*	*
302.83	Sexual Masochism	Sexual masochism	302.83	*	*
302.84	Sexual Sadism	Sexual sadism	302.84	*	*
302.3	Transvestic Fetishism	Transvestic Fetishism	302.3	*	*
302.82	Voyeurism	Voyeurism	302.82	*	*
302.9	Paraphilia NOS	Unspecified psychosexual disorder	302.9	*	*
		Zoophilia	302.1	*	*
GENDER IDENTITY DISORDERS					
302.6	Gender Identity Disorder in Children	Gender Identity Disorder in Children	302.6	*	*
302.85	Gender Identity Disorder in Adolescents or Adults	Gender identity disorder in adolescents or adults	302.85	*	*
302.6	Gender Identity Disorder NOS	Disorders of psychosexual identity	302.6	*	*
302.9	Sexual Disorder NOS	Unspecified psychosexual disorder	302.9	*	*
		Ego-dystonic sexual orientation	302.0	*	*
		Transexualism, with unspecified sexual history	302.50	*	*
		Transexualism, with asexual history	302.51	*	*
		Transexualism, with homosexual history	302.52	*	*
		Transexualism, with heterosexual history	302.53	*	*
		Other specified psychosexual disorder, other	302.89	*	*
		Unspecified psychosexual disorder	302.9	*	*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	ICD-9-CM 2002 DEFINITION	ICD-9-CM 2002 CODE	Child	Adult
EATING DISORDERS					
307.1	Anorexia Nervosa	Anorexia nervosa	307.1	B	B
307.51	Bulimia Nervosa	Bulimia nervosa	307.51	B	B
307.50	Eating Disorder NOS	Eating disorder, unspecified	307.50	B	B
SLEEP DISORDERS					
PRIMARY SLEEP DISORDERS					
DYSSOMNIAS					
307.42	Primary Insomnia	Persistent disorder of initiating or maintaining sleep	307.42	*	*
307.44	Primary Hypersomnia	Persistent disorder of initiating or maintaining wakefulness	307.44	*	*
347	Narcolepsy	Narcolepsy, without cataplexy	347.00	*	*
		Narcolepsy, with cataplexy	347.01	*	*
780.57	Breathing-Related sleep Disorder	Other sleep disturbances	780.57	*	*
327.31	Circadian Rhythm Sleep Disorder: Delayed sleep phase type	Circadian Rhythm Sleep Disorder Delayed sleep phase type	327.31	*	*
327.35	Circadian Rhythm Sleep Disorder: Jet lag type	Circadian Rhythm Sleep Disorder: Jet lag type	327.35	*	*
327.36	Circadian Rhythm Sleep Disorder: Shift work type	Circadian Rhythm Sleep Disorder: Shift work type	327.36	*	*
327.30	Circadian Rhythm Sleep Disorder: Unspecified type	Circadian Rhythm Sleep Disorder: Unspecified type	327.30	*	*
307.47	Dyssomnia NOS	Other dysfunctions of sleep stages or arousal from sleep	307.47	*	*
		Narcolepsy in conditions classified elsewhere, without cataplexy	347.10	*	*
		Narcolepsy in conditions classified elsewhere, with cataplexy	347.11	*	*
PARASOMNIAS					
307.47	Nightmare Disorder	Other dysfunctions of sleep stages or arousal from sleep	307.47	*	*
307.46	Sleep Terror Disorder	Sleep arousal disorder	307.46	*	*
307.46	Sleepwalking Disorder	Sleep arousal disorder	307.46	*	*
307.47	Parasomnia NOS	Other dysfunctions of sleep stages or arousal from sleep	307.47	*	*
SLEEP DISORDERS RELATED TO ANOTHER MENTAL DISORDER					
327.02	Insomnia Related to... (*Indicate the Axis I or Axis II Disorder)*	Persistent disorder of initiating or maintaining sleep	327.02	*	*
327.15	Hypersomnia Related to... (*Indicate the Axis I or Axis II Disorder)*	Persistent disorder of initiating or maintaining wakefulness	327.15	*	*
OTHER SLEEP DISORDERS					
327.01	Sleep Disorder Due to... *(Indicate the General Medical Condition)* Insomnia Type	Other insomnia	327.01	*	*
327.14	Sleep Disorder Due to... *(Indicate the General Medical Condition)* Hypersomnia Type	Other hypersomnia	327.14	*	*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	ICD-9-CM 2002 DEFINITION	ICD-9-CM 2002 CODE	Child	Adult
327.44	Sleep Disorder Due to... *(Indicate the General Medical Condition)* Parasomnia Type	Other sleep disturbance	327.44	*	*
327.8	Sleep Disorder Due to... *(Indicate the General Medical Condition)* Mixed Type	Other sleep disturbance	327.8	*	*
---.--	Substance-Induced Sleep Disorder *(refer to Substance-Related Disorders for substance-specific codes)*			*	*
		Specific disorders of sleep of nonorganic origin	307.4	*	*
		Nonorganic sleep disorder, unspecified	307.40	*	*
		Transient disorder of initiating or maintaining sleep	307.41	*	*
		Transient disorder of initiating or maintaining wakefulness	307.43	*	*
		Repetitive intrusions of sleep	307.48	*	*
		Specific disorders of sleep of nonorganic origin, other	307.49	*	*
IMPULSE-CONTROL DISORDERS NOT ELSEWHERE CLASSIFIED					
312.34	Intermittent Explosive Disorder	Intermittent explosive disorder	312.34	*	*
312.32	Kleptomania	Kleptomania	312.32	*	*
312.33	Pyromania	Pyromania	312.33	*	*
312.31	Pathological Gambling	Pathological gambling	312.31	*	*
312.39	Trichotillomania	Other disorders of impulse control, not elsewhere classified	312.39	*	*
312.30	Impulse-Control Disorder NOS	Impulse control disorder, unspecified	312.30	*	*
		Disorders of impulse control, not elsewhere classified	312.3	*	*
		Isolated explosive disorder	312.35	*	*
ADJUSTMENT DISORDERS					
309.0	Adjustment Disorder With Depressed Mood	Adjustment Disorder With Depressed Mood	309.0	B	B
309.24	Adjustment Disorder With Anxiety	Adjustment Disorder With Anxiety	309.24	B	B
309.28	Adjustment Disorder With Mixed Anxiety and Depressed Mood	Adjustment Disorder With Mixed Anxiety and Depressed Mood	309.28	B	B
309.3	Adjustment Disorder With Disturbance of Conduct	Adjustment Disorder With Disturbance of Conduct	309.3	B	B
309.4	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct	309.4	B	B
309.9	Adjustment Disorder Unspecified	Unspecified adjustment reaction	309.9	B	B
		Adjustment reaction, prolonged depressive reaction	309.1	*	*
		Adjustment reaction, with predominant disturbance of other emotions	309.2	*	*
		Adjustment reaction, emancipation disorder of adolescence and early adult	309.22	*	*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	ICD-9-CM 2002 DEFINITION	ICD-9-CM 2002 CODE	Child	Adult
		life			
		Adjustment reaction, specific academic or work inhibition	309.23	*	*
		Adjustment reaction, other	309.29	*	*
		Adjustment reaction, other specified adjustment reactions	309.8	*	*
		Adjustment reaction with physical symptoms	309.82	*	*
		Adjustment reaction with withdrawal	309.83	*	*
		Adjustment reaction, other specified adjustment reactions, other	309.89	*	*
PERSONALITY DISORDERS					
301.0	Paranoid Personality Disorder	Paranoid personality disorder	301.0	B	B
301.20	Schizoid Personality Disorder	Schizoid personality disorder, unspecified	301.20	B	B
301.22	Schizotypal Personality Disorder	Schizotypal personality disorder	301.22	B	B
301.7	Antisocial Personality Disorder	Antisocial personality disorder	301.7	B	B
301.83	Borderline Personality Disorder	Borderline personality disorder	301.83	B	B
301.50	Histrionic Personality Disorder	Histrionic personality disorder, unspecified	301.50	B	B
301.81	Narcissistic Personality Disorder	Narcissistic personality disorder	301.81	B	B
301.82	Avoidant Personality Disorder	Avoidant personality disorder	301.82	B	B
301.6	Dependent Personality Disorder	Dependent personality disorder	301.6	B	B
301.4	Obsessive-Compulsive Personality Disorder	Obsessive-compulsive personality disorder	301.4	B	B
301.9	Personality Disorder NOS	Unspecified personality disorder	301.9	B	B
		Affective personality disorder, unspecified	301.10	*	*
		Chronic hypomanic personality disorder	301.11	*	*
		Chronic depressive personality disorder	301.12	*	*
		Introverted personality	301.21	*	*
		Explosive personality disorder	301.3	*	*
		Other histrionic personality disorder	301.59	*	*
		Passive-aggressive personality	301.84	*	*
		Other personality disorder, other	301.89	*	*
OTHER CONDITIONS THAT MAY BE FOCUS OF CLINICAL ATTENTION					
PSYCHOLOGICAL FACTORS AFFECTING MEDICAL CONDITION					
316	*... (Specified Psychological Factor)...Affecting... (Indicate the General Medical Condition)*	Psychic factors associated with diseases classified elsewhere	316	*	*
MEDICATION-INDUCED MOVEMENT DISORDERS					
332.1	Neuroleptic-Induced Parkinsonism	Secondary Parkinsonism	332.1	*	*
333.92	Neuroleptic Malignant Syndrome	Neuroleptic malignant syndrome	333.92	*	*
333.7	Neuroleptic-Induced Acute Dystonia	Symptomatic torsion dystonia	333.7	*	*
333.99	Neuroleptic-Induced Acute Akathisia	Other extrapyramidal diseases and abnormal movement disorders	333.99	*	*

DSM-IV-TR CODE	DSM-IV-TR DEFINITION	ICD-9-CM 2002 DEFINITION	ICD-9-CM 2002 CODE	Child	Adult
333.82	Neuroleptic-Induced Tardive Dyskinesia	Orofacial dyskinesia	333.82	*	*
333.1	Medication-Induced Postural Tremor	Essential and other specified forms of tremor	333.1	*	*
333.90	Medication-Induced Movement Disorder NOS	Unspecified extrapyramidal disease and abnormal movement disorder	333.90	*	*
OTHER MEDICATION-INDUCED DISORDER					
995.2	Adverse Effects of Medication NOS	Unspecified adverse effect of drug, medicinal and biological substance	995.2	*	*
ADDITIONAL CODES					
300.9	Unspecified Mental Disorder (nonpsychotic)	Unspecified nonpsychotic mental disorder	300.9	*	*

- "*" Does not meet Medical Necessity Requirements if this is the only Axis 1 (or 2) diagnosis, even though a qualifying Axis V CGAS or GAF score has been submitted.

- "A" Meets Medical Necessity Requirements, if this is the only Axis 1 (or 2) diagnosis AND a qualifying axis V CGAS or GAF score has been submitted. (Children under 6 do not require an Axis V CGAS score.)

- "B" Meets Medical Necessity Requirements, if this is the only Axis 1 (or 2) diagnosis AND a qualifying CGAS or GAF score has been submitted AND additional criteria are met. (Children under 6 do not require an Axis V CGAS score.) See Section VI, attachments A, B, and C for information on "additional criteria."

DC03R to DSM-IV-TR Crosswalk				
Axis	**DC03R Code**	**DC0R3 Definition**	**DSM IV TR Code**	**DSM IV-TR Definition**
I	100	Posttraumatic Stress Disorder	309.81	Posttraumatic Stress Disorder
	150	Deprivation/Maltreatment Disorder	313.89 (B)	Reactive Attachment Disorder of Infancy or Early Childhood
I	200	Disorder of Affect		
	210	Prolonged Bereavement/Grief Reaction	296.90	Mood Disorder NOS
	220	Anxiety Disorders of Infancy and Childhood		
	221	Separation Anxiety Disorder	309.21	Separation Anxiety Disorder
	222	Specific Phobias	300.29 (B)	Specific Phobias
	223	Social Anxiety Disorder	300.23 (B)	Social Anxiety Disorder
	224	Generalized Anxiety Disorder	300.02	Generalized Anxiety Disorder
	225	Anxiety Disorder NOS	300.00	Anxiety Disorder NOS
	230	Depression of Infancy and Early Childhood		
	231	Major Depression	296.20	Major Depression, Single Episode unspecified.
	232	Depressive Disorder NOS	311	Depressive Disorder NOS
	240	Mixed Disorder of Emotional Expressiveness	296.90	Mood Disorder NOS
I	300	Adjustment Disorder	309.9 (B)	Adjustment Disorder Unspecified

DC03R to DSM-IV-TR Crosswalk				
Axis	**DC03R Code**	**DC0R3 Definition**	**DSM IV TR Code**	**DSM IV-TR Definition**
I	400	Regulatory Disorders of Sensory Processing		
	410	Hypersensitive	312.9 (B)	Disruptive Behavior Disorder NOS
	411	Type A: Fearful/Cautious		
	412	Type B: Negative/Defiant		Dissociative Disorder NOS
	420	Hyposensitive/ Under-responsive	300.15 (B)	Disruptive Behavior Disorder NOS
	430	Sensory Stimulation-Seeking/ Impulsive	312.9 (B)	
I	500	Sleep Behavior Disorders		
	510	Sleep Onset Disorder	307.47*	Dyssomnia NOS
	520	Nightwalking Disorder	307.47*	Nightwalking Disorder
I	600	Feeding Behavior Disorders	307.59 (B)	Feeding Disorder of Infancy or Early Childhood
	601	Feeding Disorder of State Regulation		
	602	Feeding Disorder of Caregiver-Infant Reciprocity		
	603	Infantile Anorexia		
	604	Sensory Food Anorexia		
	605	Feeding Disorder Associated With Concurrent Medical Condition		
	606	Feeding Disorder Associated With Insults to the Gastrointestinal Track		
I	700	Disorders of Relating and Communicating		
	710	Multisystem Developmental Disorder (MSDD) [under 2]	298.9	Psychotic Disorder NOS
		[2 or older - Use DSM PPD diagnosis]	299.80*	Asperger's Disorder and PPD NOS
			299.00*	Autism
I	800	Other Diagnoses (Identify DSM IVTR diagnosis when it most appropriately fits the situation with the child)		
I	900	All Relationship Disorders (estimate severity with PIR GAS)	313.9	D/O of infancy/childhood/adol NOS

* not accepted by the State of Washington's Access to Care Guideline covered diagnoses (B) Diagnoses which need justifications

Axis III	
All relevant medical problems as in DSM IV-TR	
Axis IV	
0	None
1	Mild
2	Moderate
3	Severe

Axis V

There is no Axis V equivalent in the DC03. The Axis V tool used in DC03 does not yield a 100 scale and requires a high level of expertise in infant/early childhood development. GAF is not valid for children and CGAS is not valid for children under 6. Consistent with the Access to Care diagnostic guidelines no number score between 0 and 100 can be given for children from birth through age 5. To justify an Access to Care "B" diagnosis listed in the crosswalk chart above the evaluation of the child, or child/caregiver interaction must conform to the Access to Care language for documenting a severe abnormality in the child's overall functioning as indicated by the following:

- Atypical behavior patterns as a result of an emotional disorder or mental illness (odd, disruptive or dangerous behavior which is aggressive, self-injurious, or hypersexual; display of indiscriminate sociability/excessive familiarity with strangers).
- Atypical emotional response patterns as a result of an emotional disorder or mental illness which interferes with a child's functioning (e.g. inability to communicate emotional needs; inability to tolerate age-appropriate frustrations; lack of positive interest in adults and peers or a failure to initiate or respond to most social interaction; fearfulness or other distress that doesn't respond to comfort from caregivers).

Disorders of Regulation and Sensory Processing are specifically included by the above (bulleted language from the Access to Care guidelines) when they are manifest in all settings and overwhelm a child's capacity for self-regulation. They may lead to coordination difficulties, irritability or withdrawal that seriously impacts functioning. Sensory Processing difficulties include extreme reactivity to touch, light, noise, etc. that cannot be avoided in the child's environment and cannot be adequately ameliorated by the adults involved with the infant/child. Functional consequences include distorting relationships with adults and other children. These disorders must have clear and serious impact on the child's physical and/or psychological development and health.

Serious Relationship Disturbances, including those that manifest in infantile and early childhood eating disorders and impact attachment behavior are specifically included by the above language. These Relationship Problems can be rated on the PIR-GAS scale. A score of 70 or below would be considered evidence of a disturbance in the relationship between the infant/child and their parent/caregiver that would meet the criteria for functional disturbance in the above language. In such cases a parent/caregiver's behavior leads to immediate and specific dysfunctional behaviors in the child that may lead to increasingly dysfunctional, sometimes abusive or grossly ineffective, behaviors by the parent/caregiver. Such patterns observed in "real time" meet the above standards for allowable "B" diagnoses when dysfunctional relationship patterns show signs of distorting the physical and psychological development of the infant/child and becoming the substrate for, or a significant causal factor for future childhood mental health problems.

Eating behavior dysfunction; i.e. distorted food interest and dysregulated cycles of hunger and satiation that lead to serious consequences in physical growth and health.

Additional Criteria for Diagnosis B

An individual with a "B" diagnosis must meet at least one of the following criteria to be considered for a level of care placement decision. Behaviors/symptoms must be the result of a mental illness.

* High Risk Behavior demonstrated during the previous 90 days – aggressive and/or dangerous, puts self or others at risk of harm, is at risk of grave disability, is at risk of psychiatric hospitalization or at risk of loss of current placement due to the symptoms of a mental illness
* Two or more hospital admissions due to a mental health diagnosis during the previous two years
* Psychiatric hospitalization or residential treatment due to a mental health diagnosis of more than six months duration in the previous year OR is currently being discharged from a psychiatric hospitalization
* Received public mental health treatment on an outpatient basis within the PIHP system during the previous 90 days and will deteriorate if services are not resumed (crisis intervention is not considered outpatient treatment)

Attribute: Axis Subtype

Transaction:
Diagnosis

Definition:
- The Diagnosis Subtype Attribute is used to identify whether or not the diagnosis is the primary focus of treatment.

Procedure:
- This attribute must be used in conjunction with the Diagnosis Axis Attribute.
- Only one diagnosis shall be identified as the primary focus of treatment.
- Only one Axis I or Axis II diagnosis shall be identified as the primary focus of treatment.
- If the primary focus of treatment changes during an outpatient or residential benefit, the change does not need to be submitted until diagnostic data is next required.

Documentation:
See Diagnosis Code.

Examples:
1. An adult client is diagnosed with major depression and mental retardation. The current treatment plan addresses problems due to the major depression. Code major depression as the primary focus of treatment.
2. A child has an attention-deficit hyperactivity disorder and a social phobia. The treatment plan focuses primarily on the ADHD. Code the ADHD as the primary focus of treatment.

Valid Codes	Definition
01	Primary focus of treatment.
00	Not primary focus of treatment.

Transaction: Disability

Definition:
Describes disabilities other than the disability of mental illness.

Required for:
All outpatient or residential benefits paid on a case rate basis, all programs

Procedure:
Multiple unique "impairment kind" codes may be submitted for the same KCID/event date. There is no 'C' (change) action code available if you wish to change the "Impairment Kind." If "Impairment Kind" for a previously submitted disability transaction must be changed, submit a 'D' (delete) followed by an 'A' (Add). "Substance Abuse" can be changed using action code "C."

Frequency:
Assessment
On change

Transaction ID: 050.03

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Event Date	Text (YYYYMMDD)	8	
Impairment Kind	Text	10	Y
Substance Abuse	Text	1	Y
King County ID	Text (number)		

Attribute: *Impairment Kind*

Transaction:
Disability

Definition:
The set of codes which identifies a person's disability, other mental health diagnosis, or conditions. To determine when a problem area should be identified as a disability, the general criteria are that disabilities should have a major impact on the person and his/her ability to function in the community. Examples of community functioning are the ability to procure food, clothing, and a safe place to live without assistance.

Procedure:
- Whenever any disability code is submitted, resubmit all currently applicable disability codes.
- Enter up to three applicable disability codes in a single transaction. This is the maximum number of two character codes that can be juxtaposed in a single 'Impairment Kind' field. If codes are concatenated, they are split out into separate rows in the database.
- Do not use codes 10 or 99 in conjunction with any other codes.
- This is a state-required field.

Required Documentation:
- For each coded disability, provider shall document the rationale for determining the existence of a disability. If this is not available, state why in the client's record.
- If code 80 is used (other disabilities not listed), provider records must identify the disability.
- For each coded disability, documentation shall include the date of onset, the impact on the client's functioning, identification of other systems providing services to the client, information about collaborative service planning and provision and impact of other disabilities on the client's mental health.

Examples:
1. A client reported having an auditory disability during an earlier assessment. This was reported in a transaction. Six months later the client acquired a medical disability. Submit codes 33 and 44 with the date of onset of the medical disability.
2. During the initial assessment, documentation is provided verifying that a client is mentally retarded and has a visual disability. Report codes 24 and 31 with the assessment date.
3. A client is diagnosed with congestive heart failure and HIV. Report Code 44 once only.

Type: VarChar (10)

Valid Codes	Definition
10	None – No disability. Do not use in conjunction with any other impairment kind codes (Normally multiple impairment codes can be entered in this field).
	Limits development of intelligence
20	Developmental – ITA ONLY
23	Developmental Disability – Physical A physical impairment or loss of function attributable to the brain or CNS (e.g. cerebral palsy), manifested before age 22, which is likely to continue indefinitely and results in substantial limitation in three or more specified areas of functioning and requiring specific and lifelong or extended care. See Public Law 95-602 (1978).
24	Developmental Disability – Mental A disability attributable to an intellectual impairment (not a mental illness) as evidenced by a diagnosis of mental retardation, or an IQ of approximately 70 or below, or inclusion for services in the Department of Developmental Disabilities. This disability must be manifested before age 22, is likely to continue indefinitely, and results in substantial limitation in three or more specified areas of functioning, requiring specific and lifelong or extended care. See Public Law 95-602 (1978).
	Sensory or communication
30	Sensory or communication - ITA ONLY
31	Visual disability
32	Deaf: A hearing impairment of such severity that the individual must depend primarily upon visual communication such as writing, lip reading, manual communication and gestures. In general, an individual with a loss exceeding 80 decibels in the conversational range is considered to be deaf.
33	Hard of hearing: A hearing impairment resulting in a functional loss, but not to the extent the individual must depend primarily upon visual or tactile communication. The hearing loss should be a significant factor in the symptoms of the mental illness, (e.g., increasing anxiety, suspiciousness or isolation); in the person's level of functioning; or in the provision of treatment.
34	Other communication difficulties (speech and language, language comprehension). (Does not include non-native speakers.)
	Other
43	Medically compromised: A person considered to be "medically compromised homebound" has a chronic medical condition, physical or psychiatric, which causes significant disability such that the individual is (1) unable to leave home, or (2) if leaving home is possible, this occurs infrequently, is usually for the purpose of receiving medical care, and requires considerable effort, supervision or assistance. Because of this difficulty or inability to leave home, the medically compromised homebound individual is unable to utilize services if provided only in a clinic.
44	Medical or physical disabilities including chronic illness not listed above. Do not submit duplicates of this code, regardless of the number of conditions that the code defines.
45	Neurological disabilities not listed above
50	Mobility
80	Other disabilities not listed above

Attribute: Substance Abuse

Transaction:
Disability

Definition:
This attribute codes a client's abuse or dependence on drugs and/or alcohol.

Procedure:
- **Drug** refers to an individual who currently or within the past year has abused or had a dependence on drugs.
- **Alcohol** refers to an individual who currently or within the past year has abused or had a dependence on alcohol.
- **Drug and Alcohol** refers to an individual who currently or within the past year has abused or had a dependence on both drugs and alcohol.
- **None** refers to an individual who has no history of abuse or dependence on alcohol or drugs.

Note: Time frame for definitions above was changed from 90 days to past year starting 1/1/2002.

Required Documentation:
Providers must document the source of information used to determine the appropriate code. Examples of sources of information: the client reported; the client's chemical dependency professional reported; the client's parole officer reported; the hospital record indicated; the clinician observed.

Examples:
1. During the assessment for services, a client stated she became clean and sober from alcohol two months ago. The clinician has obtained no information that conflicts with this report. Code 2 until one year after the client last used.
2. A client reports to his case manager that he has an occasional social drink. The case manager has observed no impact of alcohol on the client's life in general or related to treatment. Code 8.

Type: Character (1)

Valid Codes	Definition
1	Drug
2	Alcohol
3	Drug and alcohol
6	Client denies – clinician suspects abuse or dependence
7	Drug or alcohol abuse or dependence - IN REMISSION for a year or more.
8	No abuse or dependence

Transaction: HIPAA Health Care Claims 837 Professional

Definition:
In 1996, the Health Insurance Portability and Accountability Act (HIPAA) became law. It requires, among other things, that the U.S. Department of Health and Human Services establish national standards for electronic health care transactions and code sets (Transactions Rule).

The Transactions Rule requires MHCADSD and all other covered entities to use standard HIPAA transactions for electronic exchange of data that are covered under HIPAA. This requires MHCADSD to receive and providers to send service data using the HIPAA Health Care Claims 837 Professional (837P) transaction.

The HIPAA 837P replaced the existing CPT Service Detail transaction on October 16, 2003. Data from the HIPAA 837P transaction is translated into the legacy CPT Service Detail to be processed and posted to the MHCADSD IS. See the CPT Service Detail transaction.

Required for:
Outpatient, Residential, Crisis

Collection Frequency:
On event

Transaction Format:
For complete description of the HIPAA 837 Professional transaction's data elements and segments, refer to the following documents:

- X12N Health Care Claim: 837 Professional Implementation Guide, version ASC X12N 837 (005010X222A1) published June 2010. This document is available electronically at www.wpc-edi.com.

For additional site-specific transaction processing information, refer to the following document:

- MHCADSD and KCMHP Providers Trading Partner Agreement (Section XII, Attachments C and D)

Transaction: Income Category

Definition:
Describes a person's income and family size.

Required for:
Outpatient, Residential

Frequency:
Assessment
On change

Transaction ID: 060.04

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Event Date	Text (YYYYMMDD)	8	
Annual Income	Text (number)	6	
Family Size	Text (number)	2	
King County ID	Text (number)		

Attribute: *Annual Income*

Transaction:
Income Category

Definition:
This identifies the income of the family reported in the "Family Size" attribute.

Procedure:
- Report the total annual household income at authorization start.
- Report on change when the change is large enough to cause the client to be over or under the Federal Poverty level (for their family size).
- Annual Income is linked with Family Size to assist in eligibility determination.
- This will be used to determine whether a client's income level is at or above the federal poverty level.
- Federal poverty level guidelines are updated every year.
- Foster children always have an income of 0 and a family size of one.

Required Documentation:
- Providers shall document the client's total family income in the client record.
- Documentation must include the number of individuals reported who meet the definition of family members in the "Family Size" attribute and the source of information about the client's household income (e.g., income tax returns, client/family member self report).

Type: Integer

Attribute: *Family Size*

Transaction:
Income Category

Definition:
The actual number of related individuals living in the household who are dependent on the household income. Use information as reported by the client.

Procedure:
- For an adult client, members of a household who can be counted are the Medicaid client, his/her elderly or disabled parent, dependent children under the age of 18, spouses.
- Do not count siblings or children over the age of 18 unless the children are disabled.
- For the purpose of this attribute, elderly means a person aged 60 and older. See "Impairment Kind" attribute for definitions of disabled.
- If the client is a child, members of a household who can be counted are the Medicaid client, his/her parents (married or unmarried), stepparents (if not divorced from the parent), adoptive parents, and siblings under the age of 18.
- Foster children always have a family size of one.
- This transaction is used 1) to calculate whether or not the client's income is at or above the federal poverty definition; and 2) to determine a person's eligibility (self-pay) for services when not covered by Medicaid. Self-pay status is greater than 200% of the federal poverty level for adults and 300% of the federal poverty level for children. A self-pay client is not eligible for MHP services.
- If the family size is unknown , enter the value 99 for family size . Where the family size is unknown, the client will be treated as exceeding any qualifying income levels for purposes of determining non-Medicaid eligibility.

Required Documentation:
A description of "family" for each client must be documented in the client's record.

Examples:
1. If the client lives alone, report as one.
2. If the client shares his/her household with three other people who meet the criteria above, report four.
3. If the client shares his/her household with three people who do meet the criteria above and two people who **do not** meet this criteria, report four.

Type: Number (2)

Transaction: Medicaid Coverage

Definition:
Describes the coverage available to the client for mental health services as of the date reported in the event date.

Procedure:
This transaction must be submitted for all outpatient and residential benefits paid on a case rate basis. See individual attributes for unknown or not applicable codes.

During an authorization's pre-approval period the MHCADSD IS determines if a discrepancy exists between Provider One's data (as stored in the MHCADSD IS) and agency-submitted data regarding the client's Medicaid coverage on the authorization's start date. (An authorization is not approved until any such discrepancy is rectified).

To perform this evaluation, the MHCADSD IS uses the agency-submitted Medicaid transaction with the most recent event date, where the event date is less than or equal to the authorization's start date. Data conflicts with another agency's submission for the same individual on the same event date can be avoided by using the authorization's assessment date (rather than the first of the month).

Required for:
Outpatient, Residential

Frequency:
Initial Assessment
On change

Transaction ID: 140.07

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Event Date	Text (YYYYMMDD)	8	
CSO Identifier	Text	2	Y
Medicare Indicator	Text	1	Y
Private Pay Indicator	Text	1	Y
Third-Party Coverage Indicator	Text	1	Y
ProviderOne ID	Text	11	
KCID	Text (number)	10	

Attribute: *CSO Identifier*

Transaction:
Medicaid Coverage

Definition:
This attribute identifies the location of the Community Service Office (CSO) where the client is Medicaid-enrolled and eligible under federal Medicaid (Title XIX) for Mental Health benefits in King County MHP.

Procedure:
- Providers shall determine Medicaid status and CSO as part of the assessment process and in each subsequent month during the authorized outpatient or residential benefit period.
- The *CSO Identifier* field cannot be left blank.
- A note about CSO 95:
  CSO 95 is used *only* when the Provider One Portal shows RSN (other than King County) coverage for the client. If the client is a foster child and lives out of King County and has coverage under a different RSN, use CSO 95. If the client is an adult and is in a protected address program and lives in King County and Provider One shows Thurston-Mason RSN (Central Medicaid CSO), use CSO 95.

Required Documentation:
- Providers must document the source used to verify a client's Medicaid eligibility.
- If an electronic database was used to confirm eligibility, providers shall maintain receipt of confirmations or print-outs.

Example:
1. At the time of assessment, the client provided her ProviderOne services card to the clinician. The clinician used the ProviderOne Portal to look up the client. The clinician found a "King County Regional Support Network" entry in the "Managed Care" section with a date range that covers the assessment date. Enter 91.
2. A foster parent provides documentation of foster care. Enter 95.
3. A clinician has documentation that a Medicaid client is in a confidential address program. Enter 95.

Type: Text (1)

Valid Codes	Definition
90	TXIX enrolled – Not a King County CSO. Not eligible under Medicaid.
91	TXIX enrolled – King County CSO. Eligible under Medicaid.
95	TXIX enrolled – Central Medicaid CSO (CSO #76) – Includes D Coupon children and those in a confidential address program. Eligible under Medicaid.
96	TXIX enrolled – Ticket to Work clients who present with an SO8 coupon from Okanogan County.
99	Not enrolled in TXIX. Not eligible under Medicaid.

Attribute: *Medicare Indicator*

Transaction:
Medicaid Coverage

Definition:
Indicates whether a client is covered by Medicare.

Procedure:
- These codes are in addition to Medicaid coverage.
- This field cannot be left blank.

Required Documentation:
Providers shall maintain documentation that identifies sources of mental health treatment funding. Examples of documentation include fee agreements, copies of Medicare health insurance cards, insurance verification documents.

Example:
1. A client's mental health services are funded in part by Medicaid and in part by Medicare. Submit codes indicating both Medicaid and Medicare coverage.

Type: Text (1)

Valid Codes	Definition
0	No Medicare coverage – client is not covered by Medicare
1	Medicare Hospitalization Coverage – client is covered by Medicare (Part A)
2	Medicare Full Coverage (Part A and B)
3	Medicare Part B Coverage ONLY
4	Medicare Part C *

*Medicare Part C is managed Medicare, sometimes called Medicare Advantage.

It is NOT the Medicare prescription drug coverage, which is Medicare Part D.

Attribute: *Private Pay Indicator*

Transaction:
Medicaid Coverage

Definition:
This code indicates whether a client is billed for private payment.

Procedure:
- This code includes cases where a client is making co-payments or is on a sliding fee scale.
- This field cannot be blank.

Required Documentation:
Providers shall maintain documentation that identifies sources of mental health treatment funding.

Type: Text (1)

Valid Codes	Definition
0	No private pay – client is not billed for payment from their private funds.
1	Private Pay – client is billed for payment from their private funds.

Attribute: *Third-Party Coverage Indicator*

Transaction:
Medicaid Coverage

Definition:
This code indicates whether the person has one or more sources of third-party coverage for mental health services. Third-party coverage includes all sources of funding for services provided to the client including grants and private insurance. For the purposes of this element, third-party coverage excludes coverage reported as Medicaid or Medicare.

Required Documentation:
Providers shall maintain documentation that identifies sources of mental health treatment funding. Examples of documentation include: fee agreements, copies of Medicare health insurance cards, insurance verification documents.

Type: Text (1)

Valid Codes	Definition
0	No third party coverage
1	Third-party coverage - Client has one or more sources of third-party coverage

Attribute: *ProviderOne Client ID Number*

Transaction:
Medicaid Coverage

Definition:
A ProviderOne Client ID Number used by DSHS to confirm eligibility for clients and bill claims in ProviderOne. It is a system assigned, static, 9-digit numeric identifier followed by the letters "WA." ProviderOne Client ID does not change and will follow a client for life. The ProviderOne client ID number will be printed on the client's plastic "Services Card" that will replace the paper Medical Assistance ID.

Leave this field blank if the client does not have a provider one ID. Otherwise, populate this field even though the client may have no current Medicaid coverage.

Transaction: MHRM Summary

Definition:
A summary of an individual's responses on the "Mental Health Recovery Measure" (MHRM) questionnaire, which reflects the individual's view of his/her current recovery process.

Required for: All adults reporting at least one traumatic event on the trauma history that is used for screening for trauma under the "Trauma-Informed Care Grant"

OR
All adults screened for trauma under the "Trauma-Informed Care Grant"

Frequency:
On trauma screening
Every six months after trauma screening
On discharge or grant end, if earlier

Procedure:
MHRM Summary will be rejected if there is no PSS-I Trauma History record for the RUID/Case ID with an Event Date that is on or before the MHRM Summary Event Date.

Transaction ID: 840.01

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Event Date	Text (YYYYMMDD)	8	
MHRM Total	Text (number)	3	
MHRM Missing	Text (number)	2	
King County ID	Text (number)		

Attribute: *Event Date*

Definition:
The date on which the person filled out the MHRM questionnaire.

Attribute: *MHRM Total*

Transaction:
MHRM Summary

Definition:
A number that totals the values of all responses to the Mental Health Recovery Measure questionnaire.

Procedure:

- Use the following values for the responses given, and sum the values from items 1 through 30: Strongly Disagree = 0; Disagree = 1; Not Sure = 2; Agree = 3; Strongly Agree = 4.
- See the Mental Health Recovery Measure questionnaire for instructions on answering the questionnaire, and for the exact wording of each item.
- Where clinically appropriate, encourage the person to complete any items that have been missed.
- Count as "2" (Not Sure) any items that remain unanswered.
- Minimum value allowed is "0"; maximum is "120."
- NULLS are not allowed.

Attribute: *MHRM Missing*

Transaction:
MHRM Summary

Definition:
The number of uncompleted items 1 through 30 on the Mental Health Recovery Measure questionnaire.

Procedure:

- Where clinically appropriate, encourage the person to complete any items that have been missed.
- Minimum value allowed is "0"; maximum is "30."
- NULLS are not allowed.

Transaction: Mobile Crisis Team Intervention

Definition:
Program specific information for the Mobile Crisis Team (MCT).

Required for:
Mobile Crisis Team (76)

Frequency:
Every crisis episode

Procedure:
- Required for all crisis episodes to which the MCT responds with an outreach.

Required Documentation:
- Documentation of an interview with the person, referral source, or other informant.
- Attempts at corroboration are desirable and attempts at acquiring corroborating documentation shall be noted in the provider records.

Transaction ID: 850.01

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Authorization Number	Text (number)		
Diversion Type	Text	1	Y
Primary Presenting Condition	Text	2	Y
Episode Start Date/Time	Text (YYYYMMDDHHMM)	12	
Episode End Date/Time	Text (YYYYMMDDHHMM)	12	
Homeless Indicator	Text	1	
Zip Code	Text (number)	5	
King County ID	Text (number)		

Attribute: *Diversion Type*

Transaction:
Mobile Crisis Team Intervention

Definition:
The Diversion Type is designed to identify the type of facility from which the crisis intervention diverted the person.

Type: Text (1)

Valid Codes	Definition
H	Hospital
J	Jail
N	Neither

Attribute: *Primary Presenting Condition*

Transaction:
Mobile Crisis Team Intervention

Definition:
The Primary Presenting Condition describes the perceived current state of the person at the beginning of a crisis episode that is a contributing factor to the circumstances leading to the intervention.

Type: Text (2)

Valid Codes	Definition
SA	Substance Abuse
MH	Mental Health
BT	Both

Attribute: *Episode Start Date/Time*

Transaction:
Mobile Crisis Team Intervention

Definition:
Indicates the beginning date and time (to the minute) when the MCT received the referral of this crisis event.

Procedure:
- Submit the time in a 24 hour clock format.
- Episode Start Date/Time must be the same as the Authorization Request Date of Assessment.
- Episode Start Date/Time must precede the Episode End Date/Time

Type: Date/Time (12)
YYYYMMDDHHMM

Attribute: *Episode End Date/Time*

Transaction:
Mobile Crisis Team Intervention

Definition:
Indicates the conclusion date and time (to the minute) at which the MCT is finished with the person and any immediate associated consultation.

Procedure:
- Submit the time in a 24 hour clock format.
- Episode End Date/Time must be on or before the Notice of Exit Event Date (end of the authorization).

Type: Date/Time (12)
YYYYMMDDHHMM

Attribute: *Homeless Indicator*

Transaction:
Mobile Crisis Team Intervention

Definition:
This code is used to indicate the person's homeless status as reported by the person, referral source, or other informant.

Type: Text (1)

Valid Codes	Definition
N	No
Y	Yes
U	Unknown

Attribute: *Zip Code*

Transaction:
Mobile Crisis Team Intervention

Definition:
The five-digit postal code, used by the United States Postal Service, for the person's latest mailing address.

Procedure:
- Submit the Zip Code for the location of the crisis episode if the person's Zip Code is unknown. Do not use 99999 or 77777.

Type: Text (number) (5)

Transaction: Notice of Exit

Definition:
A request by the provider to the MHP to cancel or terminate a benefit or a program authorization, or notice from the provider to the MHP that a benefit/program will not be renewed.

Procedure:
- The following benefits and programs always require a notice of exit when they end:
  - Long-term Rehabilitation (LTR – code 71) and Supervised Living (SL – code 72) benefits
  - All MHP-administered programs.
- Notice of exit transactions are required when a client exits from an outpatient benefit unless another outpatient level of care benefit (codes 2X1, 3A1, 3B1) is authorized within 90 days.
- Notice of exit transactions are required when a client exits from a Standard Supportive Housing benefit (373) unless another benefit with the same benefit/program code is authorized within 90 days.
- Notice of exit transactions are required even if a benefit is terminated automatically by the system based on a provider change and changes reported by the provider (for example, to county of residence or income).
- MHCADSD will submit disposition data to the state MHD based on Notice of Exit data. Data will only be submitted to the MHD when a client has not had an open outpatient or residential authorization for 90 days.
- MHCADSD will send a letter to inform the client that his or her services have ended when there is a termination of an authorization for any of these benefits or programs: 2X1, 3A1, 3B1, 65, 66, 71, 372, 373. A letter will also be sent when there is a cancellation of an authorization for these same benefits/programs after the authorization letter has been sent to the client. The reason given in the letter will be based on the reported Reason for Termination/Cancellation.

Required for:
All benefits/programs except 00
See the "Benefits/Programs for which Notice of Exit must be reported" table below.

Frequency:
Exit from a benefit or program.

Transaction ID: 613.01

Action Codes:

A	Add
C	Change

Field	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Event Date	Text (YYYYMMDD)	8	
Authorization Number	Text (number)		
Exit Code	Text	2	Y
Reason for Termination/Cancellation	Text	2	Y
King County ID	Text (number)		

Programs/Benefits for which Notice of Exit must be reported

Program Code	Definition	Defined Length*	TM: use 09 CX: use 11	Manual Review Required
	Outpatient Level of Care			
2X1	Outpatient Benefit with 2X case rate	X		
3A1	Outpatient Benefit with 3A case rate	X		
3B1	Outpatient Benefit with 3B case rate	X		
00	No benefit requested. Client does not meet medical necessity criteria for receiving services.			
	Additional Outpatient Services			
06	Regional Mental Health Court			
09	PES Care Manager (Harborview ED)			
25	Specialty Employment Program (SEP)		X	
35	Geriatric Regional Assessment Team		X	
48	FIRST – Pre Release			X
49	FIRST – Post Release			X
53	Mental Health Integration Project	X		
57	PACT, Engagement			
58	PACT, Enrollment			
60	HOST/PATH Outreach		X	
61	HOST Intensive Case Management/Stabilization			
64	Co-Occurring Disorder Integrated Treatment Services	X		
65	Western State Hospital Intensive Community Support Program			
66	Expanding Community Services Intensive Community Support & Recovery Program			
67	ORCSP (previously CIAP) – Pre Release			X
68	ORCSP (previously CIAP) – Post Release			X
69	Integrated Dual Disorders Treatment	X		X
77	MIST Engagement			
78	MIST Enrollment			
82	FACT, Engagement		X	X
83	FACT, Enrollment			X
86	Regional MHC Peer Support			
87	Forensic Intensive Supportive Housing			X

Program Code	Definition	Defined Length*	TM: use 09 CX: use 11	Manual Review Required
88	Co-Stars			X
101	Housing Voucher	X		
103	Re-entry Case Management	X		
104	Re-entry Boundary Spanner			
105	Behavioral Treatment			
107	MIDD Wraparound			
108	Family Treatment Court Wraparound			
109	Trauma Informed Care Grant			
111	Moral Reconation Therapy-Domestic Violence			
113	Transition Support Program			
151	Criminal Justice Liaison Program – South East (SE)	X		
152	Criminal Justice Liaison Program - King Co Correctional Facility (KCCF)	X		
153	Criminal Justice Liaison Program - Work and Education Release (WER)	X		
154	Criminal Justice Liaison Program - Community Center for Alternative Programs (CCAP)	X		
	Crisis Level of Care			
09	PES Care Manager (Harborview ED)			
13	Children's Crisis Outreach Response System (CCORS)		X	
15	CCORS Intensive Stabilization Services		X	
40	Adult Crisis Stabilization (including next day appointment)		X	
74	Adult Inpatient Diversion Bed		X	
75	Crisis Respite Program - DESC		X	
76	Mobile Crisis Team		X	
79	Crisis Diversion Interim Services			
80	Crisis Diversion Facility Team			
	Residential Level of Care			
71	Adult Long-Term Rehabilitation Benefit			
72	Adult Supervised Living Benefit			
73	Adult Long-Term Rehabilitation Benefit (Benson Heights)			
373	Standard Supportive Housing Benefit	X		
	Inpatient Level of Care			
IP	Inpatient Benefit (NOT SUBMITTED THROUGH THIS TRANSACTION; Entered by Authorizer through the CCS or Inpatient application.)			

* An "X" in the "Defined Length" column means that when a benefit or program authorization is created, an expiration date is set. No "X" means that the expiration date remains NULL (blank) until the authorization is terminated.

** An “X” in the “TM: use 09, CX: use 11” column means that the only Exit Reason accepted to terminate the program authorization is code “09” and the only Exit Reason accepted to cancel the authorization is code “11.” “09” or “11” will only be accepted for programs that have an “X” in this column.

*** An “X” in the “Manual Review Required” column means that a termination or cancellation request goes through a manual review process before being approved.

Attribute: *Event Date*

Transaction:
Notice of Exit

Definition:
For terminations, this is the effective date of the termination. For cancellations, this is the date the provider learned that the cancellation was needed. For expirations, this is the date that the provider decided not to request a renewal of the authorization (applies only to benefits or programs that have a pre-determined expiration date).

Required Documentation:
Documentation supporting the reason and the effective date.

Procedure:
- For an event resulting in termination of a benefit or program, report the date of the event.
- When a benefit will expire without renewal, the date reported should be within 90 days following the benefit expiration date.

Termination Rules:

All programs and benefits
- If the termination date is within 30 days from today (a future date), a warning is issued.
- If the termination date is more than 30 days in the future the transaction will fail.
- An agency can submit one termination change transaction. Subsequent requests should be submitted even though they will fail. Submit a help desk ticket requesting the change.

Programs and benefits with a pre-determined expiration date
In ECLS the expiration date is populated at the time the authorization request processes.
- The termination date must be less than the pre-determined expiration date.
- A change to a termination date must be made within 180 days after the expiration date.

Programs and benefits without a pre-determined expiration date
In ECLS the expiration date is null (blank) at the time the authorization request processes.
- A change to a termination date must be within 180 days of the existing termination date.

Examples:
1. Submit 20080303 when a client dies on March 3, 2008 regardless of when case manager learns of it.
2. A client tells her case manager on May 2, 2008, that she is moving to Boise on May 10. Submit May 10, 2008 in the format 20080510.
3. At the end of a "2X1" outpatient benefit authorization with an expiration date of June 2, 2008, the client is unsure if she wants to continue receiving services. She makes a plan with her therapist to contact him by the end of July with a decision. Three weeks later, on June 23, she calls the therapist and indicates that she does not think she needs further services. Submit June 23, 2008 in the format 20080623.

Type: (8)
YYYYMMDD

Attribute: *Authorization Number*

Transaction:
Notice of Exit

Definition:
This is the authorization number for the benefit or program that is ending or has ended.

Type: Integer

Attribute: *Exit Code*

Transaction:
Notice of Exit

Definition:
This code indicates cancellation, initial termination, non-renewal, or a change to a previously terminated authorization date or reason.

All case-rate benefits and some non-case rate benefits have a pre-set expiration date. That is, when these authorizations are first processed, the expiration date has a value. Whether an authorization has a pre-set expiration date or not has an impact on which Exit Code to use in the Notice of Exit transaction. Refer to the "Defined Length" column in the "Benefits/Programs for which Notice of Exit must be reported" table.

1. Cancellation: Elimination of an authorization. The authorization status code is changed from 'AA' to 'CX' and the authorization status reason is set to the submitted exit reason. These are excluded from most MHCADSD reports and from processes for submitting data to the state MHD.

   For outpatient and residential benefits paid on a case rate basis, all payments made under the benefit are recouped.

2. Termination:

   Code '2' is valid only for authorizations currently in 'AA' status. On termination, the authorization status code is changed from 'AA' to 'TM', the authorization status is set to the submitted exit reason, and the authorization termination date is changed from the pre-set expiration date (if any) to the submitted event date. If the authorization has a pre-set expiration date, then the authorization is considered "terminated" if it ends before the pre-set expiration date. The termination date submitted must be less than the preset date. See exit code '3' for an alternative approach.

   For outpatient and residential benefits paid on a case rate basis, no payments are made for the months following the termination date.

3. Expiration with no renewal: This exit code is valid only for benefits or programs that have a pre-set expiration date. The authorization status code for expired authorizations remains 'AA'.

   For benefits or programs that have a pre-defined length, a Notice of Exit is required if the provider does not submit another authorization request for the same benefit or program within 90 days after the expiration date. The authorization status reason is set to the submitted exit reason. All "Outpatient Level of Care" benefit codes shown in "Benefits/Programs for which Notice of Exit must be reported" are part of a single "outpatient benefit" so that a change from 3A1 to 2X1 does **not** require a Notice of Exit.

4. Use when submitting a notice of exit for authorizations where the expiration date is already populated and the authorization status is 'TM'. Use this code:

    - To change a previously submitted Notice of Exit termination date or exit reason.
    - To submit a required notice of exit when the MHCADSD IS has automatically terminated an authorization (e.g. a provider change).

Required Documentation:
Providers shall maintain documentation supporting the reason and the effective date.

Procedure:
- Change requests for cancelled authorizations will be rejected.
- See Reason for Termination/Cancellation/Non-Renewal Procedure for Reasons that cannot be changed.
- Submitting a new event date with code "04" for a terminated non-case-rate authorization requests, but does not make, a change to the expiration date in the master authorization table. Instead, the new date will be stored in the ma_notice_of_exit table and the request to change the expiration date will be processed manually. IS staff will review the request and change the expiration date to the newly submitted event date if the change complies with the restrictions on overlapping authorizations and other business rules.
- All tiers and some programs have a preset expiration date. Others do not. Which exit code to use may depend on whether or not the benefit/program has a preset expire date.

Type: Text (2)

Valid Codes	Definition
01	Provider requests cancellation.
02	Use for benefits/program WITH a pre-set expiration date when provider requests termination **prior** to the preset expire date. Use for programs/benefits WITHOUT a preset expiration date the first time provider requests termination.
03	Benefit or program authorization has expired and no new authorization request for the same benefit or program is planned within 90 days of the expiration date.
04	Provider requests change to a previously submitted exit reason or termination date or when the provider is submitting the required notice of exit for an automatically-terminated authorization (authorization status TM) by the MHCADSD IS (eg: provider change).

Attribute: *Reason for Termination/Cancellation/Non-Renewal*

Transaction:
Notice of Exit

Definition:
This is the reason for the cancellation, termination, or expiration of the program authorization or benefit.

Required Documentation:
Documentation must support the reason and the event (exit) date reported.

Procedure:
- If accepted as the exit reason, this code will be stored as the "status reason" in the master authorization table.
- Requests to change the following status reason will not be accepted:
  MC Medicaid coverage is not verified.
- Providers must submit a more informative code for authorizations that are assigned a status reason of "01" (Out of County) by the IS based on residential arrangement or Medicaid coverage data that the provider submitted. The provider must submit an exit reason that indicates whether: treatment was completed (code 31), a referral was made to another RSN (code 15) or to another system/facility/provider (code 16 or 17) or no referral was made (code 04).
- When an authorization is terminated or cancelled by the IS, the "status reason" in the master authorization table will not be changed by the provider-submitted exit reason. The exit reason will be stored in the ma_notice_of_exit table with the authorization number and Exit Code.

Examples:
See the "Benefits/Programs for which Notice of Exit must be reported" table at the beginning of this transaction for guidance on which programs may be terminated with an "09" code.

1. An adult is authorized to receive SEP (Specialty Employment Program – code 25) services starting May 1, 20010. Her services end July 15, 2011. At that time, the provider submits a notice of exit transaction with an Event Date of 20110715 and with code "09" as the Reason for Termination. This transaction will end the authorization: the status code will be changed to "TM" and the expiration date will be set to July 15, 2011.
2. An adult in prison is authorized to the pre-release FIRST program (code 48). He completes his sentence and leaves prison on January 2, 2008. On January 3, 2008, he begins a post-release FIRST program. The provider submits a notice of exit transaction with code 20 as the Reason for Termination and an Event Date of January 2, 2008. The authorization expire (end) date, which was NULL, is changed to January 2, 2008, the status code is changed to "TM" and the status reason code is changed to "20."
3. An adult is authorized to a 3B outpatient benefit (code 3B1) starting February 1st, 2007. The benefit expires on January 31, 2008. The client begins a new 3A (code 3A1) outpatient benefit on March 26, 2008. The provider need not submit a notice of exit transaction for the 3B benefit which ended on January 31, 2008.

4. An adult is authorized to a 3B outpatient benefit (code 3B1) starting February 1st, 2007. The benefit expires on January 31, 2008. The client begins a Standard Supportive Housing benefit on March 26, 2008. The provider must submit a notice of exit transaction for the 3B benefit, and submits a transaction with code 20 (Changing program type or provider) as the Reason for Non-Renewal.

5. An adult is authorized to a 3B outpatient benefit (code 3B1) starting February 1, 2007. Because of on-going problems with his living situation, he is assessed and approved for a Standard Supportive Housing benefit to begin January 6, 2008. The outpatient benefit provider submits a Notice of Exit transaction with an Event Date of January 5, 2008 and code 20 for Reason for Termination. The original expiration date is changed from January 31, 2008 to January 5, 2008.

Type: Text (2)

Valid Codes	Definition	Exit Type **	Additional Usage Information
02	Client died	C,T,E	
04	Client moved to another county - no referral/transfer to another RSN	C,T,E	
05	Client who did not have Medicaid at start of benefit does not now meet Non- Medicaid financial eligibility requirements (e.g., third-party payor, income too high)	C,T,E	
06	Client who had Medicaid at start of benefit lost Medicaid and is not eligible for Non-Medicaid funding	C,T,E	For termination this only applies to outpatient or residential benefits paid on a case rate basis--for other program authorizations or benefits losing Medicaid is NOT a reason to terminate.
07	Client who had Medicaid at start of benefit lost Medicaid and is eligible for Non-Medicaid funding	C,T,E	For termination this only applies to outpatient and residential benefits paid on a case rate basis--for other program authorizations or benefits losing Medicaid is NOT a reason to terminate. This should be sent whether or not the provider plans to request a new OPB authorization with Non-Medicaid funding unless a more basic reason, like "31 Client completed treatment" also applies, in which case the other reason should be reported. MHCADSD programming will determine whether a new program authorization is started within 90 days, and won't send data to MHD if it is.

Valid Codes	Definition	Exit Type **	Additional Usage Information
NO CODE SUB-MITTED	Medicaid coverage is not verified	C,T	An "MC" status reason code is assigned by the IS if an outpatient or residential benefit paid on a case rate basis is canceled because Medicaid coverage is not verified for the first month of the authorization, or if an outpatient or residential benefit paid on a case rate basis is terminated because coverage is verified for the first month but not for a subsequent month.
NO CODE SUB-MITTED	Client received an intake but did not meet medical necessity	NA	An "MN" status reason code is assigned by the IS if "00" is the only program requested and there is an intake service submitted. This only applies to Medicaid.
09	Discharge from crisis or other specified program.	T	See the "Benefits/Programs for which Notice of Exit must be reported" table for the programs that can use this reason.
11	Cancelled by provider	C	This code will only be accepted for programs with an "X" in the "09 and 11 only" column in the Program table above.
12	Client enrolled in PACE	C,T,E	
13	Client has been in hospital for 30 days and discharge is not occurring within an additional 60 days. Includes Children's Long-term Inpatient facilities	C,T,E	
14	Client has been in prison, jail, Juvenile Rehabilitation Administration facilities, or juvenile detention for 30 days and release is not occurring within an additional 30 days. [For MIO- CTP - use 42 if it applies]	C,T,E	
NO CODE SUB-MITTED	Client transferred to different MH agency within KCRSN	T	A "VC" (Vendor change) status reason code is assigned by the IS when an outpatient benefit is terminated because another provider has submitted an outpatient benefit authorization request.
15	Client desires/has been referred/transferred to another RSN for services	C,T,E	Report this when a referral or transfer to another RSN is made in conjunction with an out of county move.
16	Client referred to primary care to manage MH needs	C,T,E	

Valid Codes	Definition	Exit Type **	Additional Usage Information
17	Client-desires/has been referred/transferred to another (non-RSN, non-primary care) service system, agency or facility	C,T,E	
20	Client changing program type or provider	C,T,E	This code is needed to explain a program or provider termination date for those programs where a more informative reason than "discharge" (code 09) is required.
21	Provider is unable to provide services to client for other reason	C*,T*,E	This code should only be used if no other specific code applies.
22	No qualifying service provided	C*	This code should only be used if no other specific code applies.
23	Data error in authorization request	C	
31	Client completed treatment, no longer meets continued stay criteria, meets discharge criteria, opted in (MHC only), or graduated	C,T,E	
32	Client's whereabouts unknown (lost to contact)	C*,T*,E	
33	Client exited from program due to violating program rules, or revoked for non-compliance with court conditions	T,E	This code will only be accepted for Housing Voucher program.
34	No longer eligible: Not competent or Charges dismissed – MHC only	T	
35	Client refused services or declined to participate in program. Clinician must talk with client to use this code. If client is simply not attending treatment and cannot be reached, use code 32.	C*,T*,E	
37	Not clinically eligible – MHC only	T	
42	Returned to prison - FIRST only	T	
43	Completed sentence and declined further service – MIO – CTP only	T	
44	Released by oversight committee and/or program – FIRST only	T	

** C – cancellation; T – termination; E – expiration without renewal

* MHCADSD manual clinical review required for termination or cancellation for case-rate benefits.

Transaction: Problem Severity Summary

Definition:
The Problem Severity Summary (PSS) is an inventory that is used to assess the level of functioning of adults in a number of life domains.

Procedure:
- Scores on the PSS are used to identify focuses for treatment and to determine whether the client achieves desired outcomes.
- Use the anchors below to rate the individual. Each item is listed as a separate attribute in subsequent pages.
- Report as the event date the required reporting date (as described under "Frequency"), using the most recent contacts with the client to rate his or her functioning.
- A report will be available in the Reports application that lists all upcoming PSS reporting dates, as well as all past due PSS data that have not been submitted and posted successfully to the ea_pss table. Required data for an authorization will be considered past due unless a complete set of PSS scores is posted from the provider for the client with an Event Date that is within 30 days of the required reporting date. If, because of a termination, two required reporting dates are within 60 days of each other, a single set of data will meet the requirement as long as the Event Date is no more than 30 days after the first reporting date and no more than 30 days before the second reporting date.

Coding Definitions:
Use the following anchors to rate the client on items A-N in the Problem Severity Summary:

0 ABOVE AVERAGE: AREA OF STRENGTH RELATIVE TO AVERAGE PERSON.
- Functioning in the particular domain is consistently better than that which is typical for age, sex, and subculture.
- Never below typical expectations of the "average person."

1 AVERAGE: FUNCTIONS AS WELL AS MOST PEOPLE.
- Functions in the domain as well as most people of the same sex, age, and subculture.
- Given the same environmental forces, is able to meet usual expectations consistently. "Ordinary."

2 SLIGHT: LIMITED IMPAIRMENT OR DISRUPTION IN FUNCTIONING.
- Functioning in the domain is managed with some difficulty. Performance is just below "average" expectation.
- Slightly diminished or limited skills.
- Occasional disruption in functioning may create interference with community adaptation. Behaviors are mostly appropriate but may need prompting.
- In terms of socio-legal behavior, actions are not likely to result in arrest but may result in public disturbance/police reprimands (e.g., minor infractions, cigarettes destroying someone's papers or books).
- In terms of rating symptoms in items K-N, may exhibit slight psychiatric symptoms, e.g., some subjective distress and/or mild distortion in thought process.

3 MARKED: OBVIOUS IMPAIRMENT, INADEQUATE FUNCTIONING.

- Functioning in the domain is poorly managed. Performance is clearly below average.
- Skill deficits are obvious.
- Disturbances in functioning create noticeable disruption in overall community adaptation.
- Appropriate behavior may require significant coaching.
- In terms of socio-legal behavior, actions may result in arrest (e.g., stealing a purse, breaking others' possessions).
- In terms of rating psychiatric symptoms items K-N, symptoms are noticeable, significant subjective distress and/or thought disturbance will be noted.

4 SEVERE IMPAIRMENT: SIGNIFICANT DISRUPTION/FAILURES IN FUNCTIONING.

- Functioning in the domain is very difficult, generally leads to failure in performance.
- Skill deficits are severe, may threaten client safety or result in unsanitary living conditions.
- Disruption in functioning creates constant interference in community adaptation. Behavior is highly inappropriate; may require active assistance/guidance.
- In terms of socio-legal behavior, person shows little regard for rules or laws (e.g., flagrant violations that are likely to lead to arrest).
- In terms of psychiatric symptoms, items K-N, symptoms are severe (e.g., severe anxiety, depression, subjective distress, dissociation, incapacitating thought disturbances, prominent hallucinations, bizarre delusions, incoherence).

5 EXTREME IMPAIRMENT: OUT OF CONTROL, UNACCEPTABLE.

- Productive functioning in the domain is inconceivable at time of rating.
- Skills are absent.
- Extreme disruption in functioning makes community adaptation impossible. Behaviors are totally uncontrolled.
- In terms of socio-legal behavior, actions are extremely destructive toward property or people.
- In terms of psychiatric symptoms items K-N, extreme symptoms may include vegetative symptoms, loss of contact with reality, lack of communication, lack of orientation to time, place or person. Symptoms may indicate rapid, uncontrollable decompensation.

Required for: COD programs (64, 69)
Jail Transition Services programs (55, 56)
FACT (83)
FISH (87);
Adult and Older Adult Outpatient benefits (2X1, 3A1, 3B1) for which the first month of the benefit is paid with Mental Illness and Drug Dependency (MIDD) funds

Frequency:
For COD programs (64, 69) and Jail Transition Services programs (55, 56), at:
Authorization start and end

For FACT (83) and FISH (87) programs at:
Authorization start, each year after authorization start, and authorization end

For Adult and Older Adult Outpatient benefits (2X1, 3A1, 3B1) at:
Authorization start, six months after authorization start, and authorization end. If an authorization is terminated before the original expiration date, the PSS is required for the termination date.

Transaction ID: 640.03

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Event Date	Text (YYYYMMDD)	8	
Dangerous Behavior	Text (number)	1	Y
Socio-legal	Text (number)	1	Y
Negative Social Behavior	Text (number)	1	Y
Self-care	Text (number)	1	Y
Community Living	Text (number)	1	Y
Social Withdrawal	Text (number)	1	Y
Response to Stress	Text (number)	1	Y
Sustained Attention	Text (number)	1	Y
Physical	Text (number)	1	Y
Health Status	Text (number)	1	Y
Depressive Symptoms	Text (number)	1	Y
Anxiety Symptoms	Text (number)	1	Y
Psychotic Symptoms	Text (number)	1	Y
Dissociative Symptoms	Text (number)	1	Y
Cognitive	Text (number)	1	Y
Authorization Number	Text (number)		
King County ID	Text (number)		

PSS Definitions:

A. Dangerous Behavior
Behavior which is, intentionally or unintentionally, dangerous to self or others (e.g., self-injurious, physical harm to others, disease infection of others, setting fires, rape, cruelty to animals, walks into traffic, walks outside without proper clothing for the weather). Can include threatening self-harm or harm to others (e.g., pushing, intimidating).

B. Socio-Legal
Law-breaking behavior that does not present a physical threat to self or others. Behaviors may include breaking or destroying property, prostitution, public intoxication, disturbing the peace, stealing, cheating, fraud, touching or flashing genitals, urinating in public.

C. Negative Social Behavior
Non-dangerous social behavior that ranges in severity from arguing and annoying social behavior to behavior that interferes with others (e.g., yelling or screaming, talking to self, making noises, refusing to do chores in group living situation). At the most severe, the behaviors are offensive to others (e.g., swearing, staring, or spitting at people).

D. Self-Care
Difficulty performing daily toileting, hygiene and eating.

E. Community Living
Difficulty performing basic household responsibilities that, if not performed, may affect a community living arrangement such as cleaning, cooking, laundering, shopping, managing money, keeping appointments, arranging and using transportation, having difficulty avoiding common household dangers (e.g., leaves stove on).

F. Social Withdrawal
Social behaviors that demonstrate an inhibition from engaging in social contact or active withdrawal from social contact (e.g., mostly autonomous activities, fear of contact, non-response to initiation of contact by others, poor eye contact, extreme shyness).

G. Response to Stress
Managing stressful circumstances in ways that significantly exacerbate psychiatric symptoms or are self-destructive or harmful to others.

H. Sustained Attention
Difficulty sustaining focused attention for long enough time to permit completion of tasks commonly found in normal daily work, school, or vocational training settings.

I. Physical
Impairment in sensory/motor areas such as in seeing, hearing, speaking, walking, using arms and hands, which is not of a temporary nature or that interferes with ability to live in the community. Rate the functional impairment that the physical limitation imposes upon the person, (e.g., interference with ability to live in community).

J. Health Status
Chronic health problems that typically require consistent medical management (e.g., diabetes, hypertension, HIV, COPD, congestive heart failure). Rate the functional impairment that the health condition imposes upon the person, (e.g., interference with ability to live in the community).

K. Depressive Symptoms
Symptoms of depression such as depressed mood, excessive worry/distress, sadness/despair, hopelessness; changes in appetite, sleep, or concentration; somatization, suicide ideation.

L. Anxiety Symptoms
Anxiety including excessive tension, fears, obsessions/compulsions, somatization.

M. Psychotic Symptoms/Thought Disorder
Hallucinations, delusions or strikingly peculiar behavior (e.g., talking to oneself in public). Unusual perceptual experiences, odd beliefs, or magical thinking which influences behavior and is not consistent with a person's cultural norms. May include bizarre thought content or beliefs in extraordinary abilities or powers (e.g. ability to thought broadcast, being controlled by a dead person). May also be characterized by digressive, vague, overelaborate speech or poverty of content of speech. (Do not include dissociative symptoms).

N. Dissociative Symptoms
Disturbance of identify, feelings of unreality, loss of self-identity, intrusive flashbacks, "zoning out", poor grounding in reality, signs of personality splitting (multiple personalities).

O. Cognitive
Does the client exhibit symptoms of memory disturbance, confused, unclear thinking or communication, attention deficits, disorientation in reference to time, place or person (not associated with Dissociative Disorder or Psychotic symptoms) or is there any indication that the client has a developmental disorder, dementing process or other organic brain disorder?

Required Documentation:
- Completed PSS must be maintained in provider records for each client required to be assessed with this instrument.
- Providers shall maintain records to identify the clinical staff person by name, degree, and working job title who assessed the client on the PSS. The individual conducting the assessment can be anyone authorized by provider protocols to do so.

Type: Number

For PSS, "A" through "N":

Valid Codes	Definition
0	Above average: Area of strength relative to average
1	Average: Functions as well as most people
2	Slight impairment: Limited impairment or disruption in functioning
3	Marked impairment: Obvious impairment, inadequate functioning
4	Severe impairment: Significant disruption/failures in functioning
5	Extreme impairment: Out of control, unacceptable

For PSS "O. Cognitive" only, use:

Valid Codes	Definition
1	**No**
2	**Yes**

Transaction: PSS-I Symptoms

Definition:
Describes the individual's experience of problems related to traumatic events.

Required for:
All adults screened for trauma under the "Trauma-Informed Care Grant"

Frequency:
On trauma screening
Every six months after trauma screening
On discharge or grant end, if earlier

Procedure:
- This transaction is required for every person screened for trauma history on the trauma screening date and at each six-month anniversary of the initial screening for trauma.
- If no trauma history has been reported, submit the transaction with "0" for each of the following attributes: Problem List Total, Problem List Missing, Interference List Total, Interference List Missing.
- PSS-I Symptoms will be rejected if there is no PSS-I Trauma History record for the RUID/Case ID with an Event Date that is on or before the PSS-I Symptoms Event Date.

Transaction ID: 830.01

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Event Date	Text (YYYYMMDD)	8	
Problem List Total	Text (number)	2	
Problem List Missing	Text (number)	2	
Interference List Total	Text (number)	1	
Interference List Missing	Text (number)	1	
King County ID	Text (number)		

Attribute: *Event Date*

Definition:
The date on which the person reported his or her experience of problems related to a traumatic event.

Attribute: *Problem List Total*

Transaction:
PSS-I Symptoms

Definition:
The sum of all scores (0 – 3) on items 1 through 17 of the "PTSD Symptom Scale (PSS)" symptoms (problems and interference) section.

Procedure:
- See the symptom section of the PTSD Symptom Scale (PSS)" form for instructions on reporting values, and for the exact wording of each item.
- Where clinically appropriate, encourage the person to complete any items that have been missed.
- Count as "0" any items that remain unanswered.
- Minimum value allowed is "0"; maximum is "51."
- NULLS are not allowed.

Attribute: *Problem List Missing*

Transaction:
PSS-I Symptoms

Definition:
The number of uncompleted items 1 through 17 of the "PTSD Symptom Scale (PSS)" symptoms (problems and interference) section.

Procedure:
- Where clinically appropriate, encourage the person to complete any items that have been missed.
- Minimum value allowed is "0"; maximum is "17."
- NULLS are not allowed.

Attribute: *Interference List Total*

Transaction:
PSS-I Symptoms

Definition:
The number of areas where an individual answered "yes" indicating interference from post-traumatic problems on the "PTSD Symptom Scale (PSS)" interference section (items 1 through 9).

Procedure:
- Where clinically appropriate, encourage the person to complete any items that have been missed.
- Minimum value allowed is "0"; maximum is "9."
- NULLS are not allowed.

Attribute: *Interference Missing*

Transaction:
PSS-I Symptoms

Definition:
The number of uncompleted items in the "PTSD Symptom Scale (PSS)" interference section (items 1 through 9).

Procedure:
- Where clinically appropriate, encourage the person to complete any items that have been missed.
- Minimum value allowed is "0"; maximum is "9."
- NULLS are not allowed.

Transaction: PSS-I Trauma History

Definition:
Describes the kinds of traumatic events that an individual has experienced or witnessed and their immediate impacts on the individual.

Required for:
All adults screened for trauma under the "Trauma-Informed Care Grant"

Frequency:
On trauma screening
At next six-month anniversary after new trauma experience or new reporting of trauma

Procedure:
- If an individual initially reports no traumatic events, but later discloses an earlier traumatic event or experiences a new traumatic event, submit a new set of screening data from the "PTSD Symptom Scale (PSS)" trauma history section at the next six-month anniversary of the original trauma screening.

Transaction ID: 820.01

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Event Date	Text (YYYYMMDD)	8	
Accident Fire Explosion (01)	Text (number)	1	Y
Natural Disaster (02)	Text (number)	1	Y
Assault by Known Person (03)	Text (number)	1	Y
Assault by Unknown Person (04)	Text (number)	1	Y
Sexual Assault by Known Person (05)	Text (number)	1	Y
Sexual Assault by Unknown Person (06)	Text (number)	1	Y
Combat War Zone (07)	Text (number)	1	Y
Early Sexual Contact (08)	Text (number)	1	Y
Imprisonment (09)	Text (number)	1	Y
Torture (10)	Text (number)	1	Y
Life-threatening Illness (11)	Text (number)	1	Y
Other Trauma (12)	Text (number)	1	Y

Attribute	Type	Size	Coded
Other Trauma Description	Text	100	N
Worst Trauma	Text (number)	2	Y
Treatment Reason	Text (number)	2	Y
Physical Injury to Self	Text (number)	1	Y
Physical Injury to Other	Text (number)	1	Y
Own Life in Danger	Text (number)	1	Y
Other's Life in Danger	Text (number)	1	Y
Felt Helpless	Text (number)	1	Y
Felt Terrified	Text (number)	1	Y
King County ID	Text (number)		

Attribute: *Event Date*

Definition:
For the original screening, this is the date on which the trauma history was collected.
For recently experienced or disclosed trauma that is reported at a six-month anniversary of the original screening, use the six-month anniversary date. ("Six-month anniversary" means 6, 12, 18, etc., months after the original screening.)

Example:
A client who reported having had no particularly traumatic experiences when she was originally screened on March 15, 2011, was seriously injured, as was her son, in a car accident in June 2011. Subsequently, she talked with her therapist about her injuries, her fear for her and her son's lives, and her feelings of helplessness and terror as the accident happened. When her therapist asks if it has stirred up any old feelings from earlier experiences, she talks about feeling supported by her mother when she felt scared as a child, but does not report any other traumatic events. At the six-month anniversary, submit a new transaction with a date close to September 15, 2011, that reports "Yes" for "Accident Fire Explosion (1)," "No" for all the other kinds of trauma and "Yes" on each of the attributes about physical, cognitive, and emotional experiences of the accident.

Attributes:

Accident Fire Explosion (01)
Natural Disaster (02)
Assault by Known Person (03)
Assault by Unknown Person (04)
Sexual Assault by Known Person (05)
Sexual Assault by Unknown Person (06)
Combat War Zone (07)
Early Sexual Contact (08)
Imprisonment (09)
Torture (10)
Life-threatening Illness (11)
Other Trauma (12)

Transaction:
PSS-I Trauma History

Definition:
Indicates whether or not the individual has experienced or witnessed different kinds of traumatic events.

Procedure:
- See the "PTSD Symptom Scale (PSS)" trauma history section for instructions on reporting values, and for the exact wording of each item.
- If 2 (Yes) is reported for "Other Trauma," a brief description of it should be submitted for the "Other Trauma Description" attribute.
- Where clinically appropriate, encourage the person to complete any items that have been missed.
- NULLS are not allowed.

Valid Codes	Definition
1	**No**
2	**Yes**
9	**No answer**

Attribute: *Other Trauma Description*

Transaction:
PSS-I Trauma History

Definition:
Briefly describes the nature of reported trauma that does not fit into any of the first eleven categories of trauma reported in this transaction.

Procedure:
- If 2 (Yes) is reported for "Other Trauma," submit a brief description of the type of other trauma(s) experienced. Transaction will be rejected if this procedure is violated.
- If 1 (No) is reported for "Other Trauma", do not submit a value for this attribute (NULLS are allowed). Transaction will be rejected if this procedure is violated.
- Other traumas reported shall be documented in the clinical record.

Attribute: *Worst Trauma*

Transaction:
PSS-I Trauma History

Definition:
Indicates which of the kinds of trauma an individual has experienced or witnessed he or she found the most difficult or traumatic.

Procedure:
- Use the numbers for each type of trauma listed on the trauma history checklist (also listed with the Attribute names above) to indicate the kind of traumatic event or situation that the person found most traumatic.
- Where clinically appropriate, encourage the person to identify his or her worst trauma if this item has been missed.
- Transaction will be rejected if Code 1 (No) or Code 9 (No answer) is submitted for the type of trauma indicated as the Worst Trauma. (If the value submitted for the "Natural Disaster" attribute is "9," Worst Trauma cannot be Code 02.)
- NULLS are not allowed.

Type Code	Description
01	Accident Fire Explosion
02	Natural Disaster
03	Assault by Known Person
04	Assault by Unknown Person
05	Sexual Assault by Known Person
06	Sexual Assault by Unknown Person
07	Combat War Zone
08	Early Sexual Contact
09	Imprisonment
10	Torture
11	Life-threatening Illness
12	Other Trauma
99	Not reported

Attribute: *Treatment Reason*

Transaction:
PSS-I Trauma History

Definition:
Indicates which of the kinds of trauma that an individual has experienced or witnessed is the reason he or she is seeking treatment.

Procedure:
- Use the numbers for each type of trauma listed on the trauma history checklist to indicate the kind of traumatic event or situation for which the person is seeking treatment. (Those numbers are also listed after the Attribute names above.)
- Transaction will be rejected if Code 1 (No) or Code 9 (No answer) is submitted for the type of trauma indicated as the Treatment Reason. (If the value submitted for the "Combat War Zone" attribute is "1," Treatment Reason cannot be Code 07.)
- NULLS are not allowed.

Type Code	Description
00	Not seeking treatment for trauma
01	Accident Fire Explosion
02	Natural Disaster
03	Assault by Known Person
04	Assault by Unknown Person
05	Sexual Assault by Known Person
06	Sexual Assault by Unknown Person
07	Combat War Zone
08	Early Sexual Contact
09	Imprisonment
10	Torture
11	Life-threatening Illness
12	Other Trauma
99	Not reported

Attributes:

Physical Injury to Self
Physical Injury to Other
Own Life in Danger
Other's Life in Danger
Felt Helpless
Felt Terrified

Transaction:
PSS-I Trauma History

Definition:
For any of the traumas reported by the person, indicates whether or not certain physical, cognitive, or emotional experiences were part of the traumatic event(s)

Procedure:
- See the "PTSD Symptom Scale (PSS)" trauma history section for instructions on reporting values, and for the exact wording of each item.
- If no trauma experiences are reported, submit Code 9 for each attribute.
- Where clinically appropriate, encourage the person to complete any items that have been missed.
- NULLS are not allowed.

Valid Codes	Definition
1	**No**
2	**Yes**
9	**Not reported**

Transaction: Program Referral

Definition:
This transaction is used to report client referrals to or from other providers or other service systems.

Procedure:
Submit one transaction for each referral.

Required for:
Outpatient, Crisis

Frequency:
Initial Assessment
Discharge if applicable

Transaction ID: 616.02

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Authorization Number	Text (number)		
Event Date	Text (YYYYMMDD)	8	
Referral Type	Text	2	Y
Program type	Text	4	Y
Agency/System	Text	4	Y
Linkage Indicator	Text	2	Y
King County ID	Text (number)		

Attribute: *Event Date*

Transaction:
Program Referral

Definition:
This is the date of the referral.

Procedure:
- For a referral to or from the reporting mental health provider from or to an external system, report the date the referral was made.
- For screening contact, report the date of the first screening contact by the client.
- The Event Date must fall within the benefit or program authorization period except for screening contact and referral in.

Type: Date (8)
YYYYMMDD

Attribute: *Referral Type*

Transaction:
Program Referral

Definition:
This code identifies the referral as one of: From the provider, To the provider, or Screening Contact.

Procedure:
- Report this code for all referral types.

Required Documentation:
All referrals to or from the provider must be maintained in provider records.

Type: Text (2)

Referral Type	Description
01	Screening Contact. This code indicates that the Event Date reported was the date that the client was screened for services. Not required for Continuation of Benefit. Use Program Type and Agency / System codes 9998 Not Applicable
02	Referral into the reporting Agency. Not required for Continuation of Benefit.
03	Referral by (from) the reporting Agency.

Attribute: Program Type

Transaction:
Program Referral

Definition:
This code describes programs or services that are provided by a facility, provider, or system to meet specific needs.

Example: Head Start Program

Procedure:
- This attribute is optional for outpatient benefits and most other programs; use Code 9998.
- This attribute is required for program codes 09 (PES Care Manager), 35 (Geriatric Regional Assessment Team), and 103 (Re-entry Case Management.
- Referrals to a specific RSN-funded program may be reported using the program codes listed under the Benefit/Program attribute of the Authorization Request transaction.
- Report this code for referrals made at the time of discharge from services.
- No report is required at expiration of a benefit where the client will continue services at the same provider agency under a continuation of benefit.
- For a referral to an RSN program, use the Program Code. See Authorization Request.

Required Documentation:
All sources of referral must be maintained in provider records.

Type: Text (4)

Program Type	Description
08	Harborview Emergency Department – ROI on file
110	Mental Health Services – General
111	Mental Health Crisis Services – General
112	Voluntary Inpatient Programs – General
113	Involuntary Inpatient Programs – General
114	Active Outreach by Mental Health Services provider
115	Mental Health Services – Outpatient Screening
116	Mental Health Services – Referral to RSN Outpatient Benefit Provider
117	Mental Health Services – Outpatient Non Network Provider
118	Mental Health Services – Provider Out of State
120	Medical Care – General
121	Emergency Medical Care – General
122	Nursing Home Programs – General
130	Legal Services – General
131	Law Enforcement / Police
132	Juvenile Justice Services
133	Legal Services – Mental Health Court

Program Type	Description
134	Alcohol & Substance Abuse Services – Involuntary
140	Alcohol & Substance Abuse Services – General
141	Alcohol & Substance Abuse Services – Detox
142	Alcohol & Substance Abuse Services – SUDNDA
143	Alcohol & Substance Abuse Services – ADATSA
144	Alcohol & Substance Abuse Services – Sobering
145	Alcohol & Substance Abuse Services – REACH
146	Alcohol & Substance Abuse Services – Inpatient Public
147	Alcohol & Substance Abuse Services – Inpatient Private
148	Alcohol & Substance Abuse Services – Outpatient Public
149	Alcohol & Substance Abuse Services – Outpatient Private
150	Residential/Housing Programs – General (excluding nursing homes)
160	Vocational Services – General
165	Veterans' court services
170	Developmental Disability Services - General
180	Other Social Services – General (may include DSHS Home and Community Services, Aging/Youth Services, and any social services other than mental health)
190	Educational Services - General
198	Other Services – General (any services not listed)
60	HOST – Outreach
61	HOST – Intensive Case Management
9151	Respite Bed Program
9152	Diversion Bed Program
9153	Temporary Housing Services
9154	Shelter Services
9998	Not applicable

Attribute: Agency / System

Transaction:
Program Referral

Definition:
These codes describe any organization or group of organizations that provide programs or services.

Example: Community Psychiatric Clinic, Division of Child and Family Services

Procedure:
- Referrals to a specific agency must be reported using the "Agency ID" in the ECLS "Agency List". Some Agency IDs are included below for convenience.
- Referrals to a system should be reported using the codes below.

Required Documentation:
- This Attribute is always required for a referral to or a referral from a reporting agency. Not required for Screening Contact.
- Provider records must document all referral sources.
- If collaborative or ongoing services are provided by a referral source, include information describing the type of ongoing involvement with the client and include this in the client's Individualized Tailored Care Plan (see Definitions).

Example:
During an outpatient benefit, the provider refers the client to a Primary Care practitioner. Report Agency/System code 1021 – Primary Care Practitioner non-specific, and report Program Type Code 9998 – Not applicable.

Type: Text (4)

Agency/System	Definition
	Mental Health System
1010	Outpatient Network Mental **Health** Providers – Non-specific
1011	Outpatient Non-network Mental Health Providers – Non-specific (including psychiatrists, counselors, treatment centers)
1012	Inpatient Mental Health Facilities – Non-specific
1013	Designated Mental Health professional
1014	Children's Crisis Response Team
1015	Geriatric Regional Assessment Team
1113	Re-entry Case Management
1114	Co-Occurring Disorder (COD) treatment program/IDDT
1125	Center for Community Alternatives Program (CCAP)
1126	King County Work and Education Release (WER)
	Medical System
1020	Inpatient Medical Facilities – Non-specific
1021	Primary Care Practitioners – Non-specific

Agency/System	Definition
1022	Emergency Rooms – Non-specific
1023	Nursing Home
1024	Ambulance Services
	Legal System
1030	Police – Non-specific
1031	Jail – Non-specific
1032	Attorneys
1033	Jail Probation Officers
1034	Court Referral, including LROs
1035	Pre-booking Diversion (HARBORVIEW EMERGENCY DEPARTMENT)
1036	Police booked or cited (HARBORVIEW EMERGENCY DEPARTMENT)
1037	Regional Mental Health Court
1038	Municipal Mental Health Court
1039	King County Drug Court
1120	Electronic Home Detention
1130	KC Superior Court Felony Drop Down (Regional MHC only)
1131	KC Regional Court Misdemeanors (Regional MHC only)
1132	City Transfer Cases (Regional MHC only)
301	King County Correction Facility (see the ECLS Agency List)
302	Regional Justice Center (see the ECLS Agency List)
303	Division of Youth Services (see the ECLS Agency List)
305	Juvenile Rehabilitation Administration (see the ECLS Agency List)
306	Seattle Police Department (see the ECLS Agency List)
307	Department of Correction (see the ECLS Agency List)
311	South Correctional Entity (SCORE) (see the ECLS Agency List)
933	Metro Transit Police (see the ECLS Agency List)
934	Sound Transit Police (see the ECLS Agency List)
	Substance Abuse Facilities
1040	Substance Abuse System – non-specific
1041	Outpatient Substance Abuse Facilities – Public, non-specific
1042	Inpatient Substance Abuse Facilities – Public, non-specific
1043	Outpatient Substance Abuse Facilities – Private, non-specific
1044	Inpatient Substance Abuse Facilities – Private, non-specific
1045	Self-help Associations (AA, NA, etc…)
490	Seattle Recovery Center (SRC) (see the ECLS Agency List)
491	South King County Recovery Center (see the ECLS Agency List)
492	Sobering Center (see the ECLS Agency List)
493	Cedar Hills Alcohol Treatment (CHAT) (see the ECLS Agency List)
	Housing System
1050	Housing System – Non-specific
	Developmental Disabilities System
1060	Developmental Disabilities System – Non-specific

Agency/System	Definition
	Vocational System
1070	Vocational System – Non-specific
	Social Services System
1110	Social Services System – Non-specific
1111	Children's Administration (formerly DCFS)
1112	DCHS
	Educational System
1080	Educational System – Non-specific
	Other Systems
1090	Other Systems – Non-specific
1091	Veteran Affairs System – Non-specific
1092	Family Support System – Non-specific (including family, friends)
1093	Community Support System – Non-specific (including ministry, community support organizations)
1094	Self-Referral
1095	Wraparound Services
1096	Parent Support System/Network
1133	Fire--Non-specific
9998	Not applicable
935	Kent Fire Department (see the ECLS Agency List)

Attribute: *Linkage Indicator*

Transaction:
Program Referral

Definition:
This code describes the type and success of the referral.

Procedure:
- Report this code for referrals made by the provider during the benefit or program authorization, and for referrals made at the time of discharge from services.
- For referrals into your agency, or for Screening Contacts, use code 98 – Not applicable.
- Programs 09 (PES Care Manager) and 35 (Geriatric Regional Assessment Team), and 103 (Re-entry Case Management) are required to follow up on referrals and report meaningful codes.

Required Documentation:
All sources of referral must be maintained in provider records.

Type: Text (2)

Valid Codes	Definition
01	Client refused
02	No services available
03	Client accepted; no linkage made
04	Linkage confirmed
07	Pending linkage; client accepted
31	Client did not connect with referral
33	Provider declined referral
35	Follow-up Plan
39	Unable to confirm linkage
98	Not applicable
99	Unknown

Transaction: Residential Absence

Definition:
This transaction is used for reporting a client's temporary absence from a residential facility.

Procedure:
- This transaction is only required when the client is living in an RSN-funded residential facility as reported in the Residential Arrangement entity.
- This transaction must be reported by the provider holding the residential authorization to document temporary leaves from a facility.
- If the client is leaving the facility permanently or moving to another facility, do not use this transaction. Instead, use the Residential Facility transaction to report the change.
- Only absence reason will be updated on Change.
- New absence record (Add) can't overlap client's existing absence record.

Required for:
LTR, Supervised Living

Frequency:
On Occurrence

Transaction ID: 115.01

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Absence Start Date	Text (YYYYMMDD)	8	
Absence Last Date	Text (YYYYMMDD)	8	
Absence Reason	Text	2	Y
Facility Code	Text	9	
KCID	Text (number)		

Attribute: *Absence Start Date*

Transaction:
Residential Absence

Definition:
The start date of client's absence from the facility

Procedure:
- Report the date the client leaves the facility.
- MHCADSD will stop the reporting of residential per-diem service to the State MHD starting on the Absence Start Date until and including the Absence Last Date.

Required Documentation:
Providers shall document all dates in clinical or personnel records.

Type: Date (8)
YYYYMMDD

Attribute: *Absence Last Date*

Definition:
This is the last date of the client's absence from the facility.

Procedure:
- Absence Last Date is a required field and cannot be null.
- When a client returns from an absence, report the Absence Last Date as the date of the last day where the client was not in the residential facility at midnight. For example, if the client returns to the facility on May 1, 2004 before midnight, then report April 30, 2004 as the Absence Last Date.
- MHCADSD will resume the reporting of residential per-diem service to the State MHD on the day following the Absence Last Date.

Required Documentation:
Provider shall document all dates in clinical or personnel record.

Type: Date (8)
YYYYMMDD

Attribute: *Absence Reason*

Transaction:
Residential Absence

Definition:
This attribute codes the reason for a client's temporary absence from a facility.

Procedure:
- Report the reason for client's absence using the code list below.

Required Documentation:
Providers shall maintain documentation supporting the reason.

Valid Codes	Definition
01	Medical Hospitalization
02	Psychiatric Hospitalization
03	Jail
04	Authorized Leave
05	Unauthorized Leave

Attribute: *Facility Code*

Transaction:
Residential Absence

Definition:
This attribute codes the exact residential facility where the client currently resides.

Procedure:
- Report the Facility Code using the Facility Code list under the Residential Facility transaction.

Transaction: Residential Arrangement

Definition:
This is an outcome measure that describes the residential arrangement of the client.

Required for:
All programs

Frequency:
Initial Assessment
On change

Transaction ID: 110.06

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Start Date	Text (YYYYMMDD)	8	
Residential Arrangement	Text	2	Y
Zip Code	Text	9	
County Code	Text	2	Y
King County ID	Text (number)		

Attribute: *Start Date*

Transaction:
Residential Arrangement

Definition:
The date a client moved into a residence or the date that the residential arrangement information was obtained from the client or the date that the residential arrangement information was reported using revised codes (see Procedure below).

Procedure:
- For Assessments, report the date that the residential arrangement information was obtained from the client.
- For On Change, report the actual date the client moved residence.
- To update Residential Arrangement data using the new set of codes effective October 1, 2011, report the date on or after October 1, 2011 when the client's residential arrangement status is reviewed and the correct code identified.

Required Documentation:
Provider shall document all dates in clinical or personnel records.

Type: Date (8)
YYYYMMDD

Attribute: *Residential Arrangement Code*

Transaction:
Residential Arrangement

Definition:
This code describes the housing arrangement of the client on the Event Date of the transaction.

Procedure:
- Report the residential arrangement on assessment and on change. On change means when client has a change from one type of housing to another.
- For the initial assessment, use the date the residential arrangement was obtained from the client as the start date.
- When there is a change in residential arrangement, report the actual date the residential arrangement change occurred.
- If a client's residential arrangement is fluctuating
- If a client's residential arrangement is fluctuating frequently among some combination of Homeless, Temporary housing, Jail, Psychiatric Inpatient, Residential Drug/Alcohol treatment, none of which are expected to last longer than 30 days (or 60 for Jail and or 90 for Inpatient Psych/Residential Drug Treatment, respectively), report the code that best describes the majority of time in the last 30 days.
- If there is a change that is expected to last for a while (for example, losing housing and becoming homeless; moving from Residential Care to Permanent Housing - assisted), report the new residential arrangement when the change occurs. That is, do not wait 16 days until "Permanent Housing – assisted" becomes the residential arrangement for the majority of time in the last 30 days.
- Dependent children and youth living with parents should be reported based on the living situation that describes the permanence and adequacy of their parents' living situation (that is, homeless, permanent, temporary or transitional), without regard to "intensive supportive services" that the parent may require. In other words, codes 01, 04, 05, or 06 could apply to a child, but 02 or 03 will not.
- This is an outcome measure.

Required Documentation:
Providers shall document the type of residence a client lives in and any changes of that place of residence.

Examples:
1. A 10 year-old client lives with her mother in a transitional housing site for women coming out of prison. Report 06 for "Transitional Housing.
2. A client receiving services under a Long-Term Residential benefit lives in an agency-operated residential facility, which is also licensed as an Institute for Mental Disease. Report 07 for "Residential Care."
3. A man who has recently been sleeping on the streets, with a few brief stays at his brother's house, is involuntarily hospitalized. Continue to report code 82 for "Homeless," unless he remains in inpatient psychiatric facilities for 90 days.
4. A 16- year-old client lives in a group home operated by another social service agency. Report 07 for "Residential Care"

Type: Text (2)

In the following definitions:

- "Intensive supporting services" includes the mental health and case management services provided by PACT High Intensity Treatment, MPC, ECS, Standard Supportive Housing, and similar programs.
- "Emancipated youth" means a youth sixteen years of age or older, who: is a resident of the state, has the ability to manage his or her financial affairs, and has the ability to manage his or her personal, social, educational, and nonfinancial affairs.

Valid Codes	Definitions
	Type of housing
01	Permanent housing – unassisted: Without intensive supporting services required to maintain housing. A house, apartment, trailer, hotel, dorm, barrack, and/or Single Room Occupancy (SRO), rented or owned, with an expectation of long-term residency. Includes dependent children living with parents or legal guardians but not in foster care.
02	Permanent housing – assisted: With intensive supporting services required to maintain housing. A house, apartment, trailer, hotel, dorm, barrack, and/or Single Room Occupancy (SRO), rented or owned, with an expectation of long-term residency.
03	Temporary housing – unassisted: Without intensive supporting services required to maintain housing, and without an expectation of long-term residency.
04	Temporary housing –assisted: With intensive supporting services required to maintain housing, and without an expectation of long-term residency.
05	Temporary housing – dependent: Living with friends or family temporarily including "couch surfing" and includes emancipated youth.
06	Transitional housing: Housing provided as part of participation in a housing readiness program with time-limited housing and supporting services provided with the goal of permanent housing.
07	Residential Care: May include a Group Home, Therapeutic Group Home, Board and Care, Residential Treatment, Rehabilitation Center, or Agency-operated residential care facilities.
08	Skilled Nursing/Nursing/Intermediate Care Facility
09	Other institutional setting: A licensed institutional treatment and care facility not covered by other codes, including: Institute of Mental Disease (IMD), DD Facility, or Medical Hospital.
22	Adult Family Home: Regular neighborhood homes licensed by the state for two to six residents where staff assumes responsibility for the safety and well-being of the adult. A room, meals, laundry, supervision and varying levels of assistance with care are provided.

Valid Codes	Definitions
25	Residential Drug/Alcohol treatment – treatment for 90 days or more. If the client is in treatment for less than 90 days, use the code for the living arrangement just prior to treatment.
26	Foster Care (for children) A Licensed Foster Home to provide foster care to children and adolescents including Therapeutic Foster Care Facilities.
61	Jail/Juvenile Correctional Facility - Incarceration for 60 days or more. If the client is incarcerated for less than 60 days, use the code for the living arrangement just prior to incarceration.
62	Psychiatric Inpatient Facility – Voluntary or involuntary hospitalization for 90 days or more; includes CLIP programs. Types of facility include Inpatient Psychiatric Hospital, Psychiatric Health Facility (PHF), Veterans Affairs Hospital, or State Hospital. If the client is hospitalized for less than 90 days, use the code for the living arrangement just prior to hospitalization.
82	Homeless - Those persons of all ages who lack a fixed, regular, and adequate nighttime residence including persons whose primary nighttime residence is one of the following: • Emergency shelter (e.g., missions, churches) where residence is on a 'night by night basis' • Living on the streets, in a vehicle, or abandoned building • Being discharged/discharged from an institution (e.g., jail, medical or psychiatric hospital) with no arranged residence • Temporary living accommodations by a voucher system (e.g., motel vouchers) • Living in a public or private place not designed for, or not ordinarily used as, a regular sleeping accommodation for human beings

Attribute: Zip code

Transaction:
Residential Arrangement

Definition:
The five-digit code for the zip code for the person's residence at the time of admission or review.

Procedure:
- If a client resides in King County, the zip code **must** be submitted.
- This will be used to identify all clients who reside within the MHCADSD/MHP service area.
- If a client is homeless, report the zip code where assessment took place. Do not report zip code again unless client has had a change in residential arrangement.
- For clients in a confidential address program, submit either the provider's zip code or e MHCADSD zip code (98104).

Required Documentation:
The client's address and zip code must be maintained in his/her clinical record.

Example:
- Client is homeless and received assessment on the corner of 3rd & James downtown Seattle. Use zip code 98104.

Type: Text (9)

Valid Codes	Definition
Five digit zip code	Zip Code
77777	Out of County - Unknown

Attribute: County Code

Transaction:
Residential Arrangement

Definition:
A code to identify client's county of residence. Codes '01' through '39' identify the 39 counties in alphabetical order. Code '99' represents unknown county.

Procedure:
- Where a provider requests a benefit for a client with an out of county code, the request requires manual review and approval by the MHP.
- For clients placed in facilities outside of King County (e.g., Western State Hospital or Pioneer Center), a change in county code should be reported when client has been there for 90 days or more.
- This information is used by the state to establish the RSN of responsibility and for the purposes of allocating resources.
- This information is used by King County to determine eligibility for services under the MHP and the RSN.
- For clients in a confidential address program, submit the code for King County.

Type: Text (2)

Valid Codes	Definition
01	Adams
02	Asotin
03	Benton
04	Chelan
05	Clallam
06	Clark
07	Columbia
08	Cowlitz
09	Douglas
10	Ferry
11	Franklin
12	Garfield
13	Grant
14	Grays Harbor
15	Island
16	Jefferson
17	King
18	Kitsap
19	Kittitas
20	Klickitat
21	Lewis
22	Lincoln

Valid Codes	Definition
23	Mason
24	Okanogan
25	Pacific
26	Pend Oreille
27	Pierce
28	San Juan
29	Skagit
30	Skamania
31	Snohomish
32	Spokane
33	Stevens
34	Thurston
35	Wahkiakum
36	Walla Walla
37	Whatcom
38	Whitman
39	Yakima
90	Out of state
98	Out of County - county unknown

Transaction: Residential Facility

Definition:
This is the entity that describes the residential facility where the client lives.

Procedure:
- This transaction is only required when the client is living in an RSN-funded residential facility as reported in the Residential Arrangement entity.
- This transaction must be reported by the provider holding the residential authorization when an authorization request is submitted for a residential program.

Required for:
LTR, Supervised Living

Frequency:
Assessment
On change

Transaction ID: 112.01

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Start Date	Text (YYYYMMDD)	8	
Exit Date	Text (YYYYMMDD)	8	
Facility Code	Text	9	Y
KCID	Text (number)		

Attribute: *Start Date*

Transaction:
Residential Facility

Definition:
The date a client moved into a residence.

Procedure:
- For assessments, report the actual start date the client began residence in the facility.
- When a client moves, report the exit date for the former facility (see Exit Date attribute for procedure) and the new start date for the new facility.
- This transaction was implemented January 1, 1998. There are no residential facility data before that date.

Required Documentation:
Providers shall document all dates in clinical or personnel records.

Type: Date (8)
YYYYMMDD

Attribute: Exit Date

Transaction:
Residential Facility

Definition:
The date a client moved out of a residence.

Procedure:
- When a client leaves the facility, report the exit date as the last day client was at the facility as of midnight.

Required Documentation:
Provider shall document all dates in clinical or personnel record.

Type: Date (8)
YYYYMMDD

Attribute: *Facility Code*

Transaction:
Residential Facility

Definition:
This attribute codes the exact residential facility where the client currently resides.

Procedure:
- Valid codes for each of the residential facilities are noted below.
- When there is a change in residence, report the actual date the residential change occurred and the new location.

Required Documentation:
Providers must document the place and type of residence a client lives in. When a residential change occurs, the records shall reflect that change.

Facility Names and Codes

Valid Codes	Definition
222	Avondale House
219	Benson Heights
164	Spring Manor
165	Cascade Hall
166	Chartley House
167	El Rey
8032	El Rey - SL
124	Firwood
221	Highwest Residence
158	Hilltop Center
169	Keystone Resources
225	Midway Residential (as of 03/04/99)
224	Stillwater
148	Transitional Resources

Transaction: Staff Person

Definition:
Information about staff employed by mental health providers.

Procedure:
It is not possible to change the "Start Date" for existing data. If a correction is required, contact the King County Help desk.

Required for:
All staff

Frequency:
On hire
On discharge

Transaction ID: 810.05

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Staff Person ID	Text	10	
Start Date	Text (YYYYMMDD)	8	
End Date	Text (YYYYMMDD)	8	
Surname	Text	30	
Given Name	Text	30	
Gender	Text	1	Y
Language Code	Text	10	Y
King County ID	Text (number)		

Attribute: *Staff Person ID*

Transaction:
Staff Person

Definition:
The identifier established by a Reporting Unit that uniquely identifies a staff person. A Staff ID submitted by a Reporting Unit should not be identical to a client Case ID submitted by that Reporting Unit. This uniquely identifies the staff person within an agency who is providing and reporting a service to a client. Where a staff person is also a case manager, the staff ID and the case manager ID should be identical.

Required Documentation:
All services provided to a client must be documented in the clinical record with the date, type, location (in/out), and duration of the service episode and the name of the clinician providing the service.

Type: Text (10)

Attribute: *Start Date*

Transaction:
Staff Person

Definition:
The date an agency staff person began employment.

Required Documentation:
Providers shall document all start and change dates in personnel records.

Type: Date (8)
YYYYMMDD

Attribute: *End Date*

Transaction:
Staff Person

Definition:
This is the date the staff person leaves the agency.

Procedure:
- For the Staff Person transaction, it is the end of the staff person's employment or volunteer work at the agency.
- Transmit a NULL if not applicable.

Required Documentation:
All end dates must be documented in provider records.

Example:
1. A case manager terminates his employment at an agency. Report the last date of employment.

Type: Date (8)
YYYYMMDD

Attribute: *Surname*

Transaction:
Staff Person

Definition:
The surname/family/last name of a staff person as provided by a Reporting Unit. In general, follow the rules of the appropriate culture when determining which name is the surname.

Procedure:
- Consistency is important; the last name will be used as one element to uniquely identify the person across our system.
- Only the following characters are allowed: alphabetic characters, hyphens, space (but not as the first character), apostrophe (single quotation mark). No numeric characters are permitted.

Type: Text (30)

Attribute: *Given Names*

Transaction:
Staff Person

Definition:
The given/first/legal names of a staff person as provided by a reporting unit. In general, follow the rules of the appropriate culture when determining which name is the surname and which the given name.

Procedure:
- Consistency in reporting each name is important; the last name and given names will be used as elements to uniquely identify the person across our system.
- The middle name is a required entry. If only the middle initial is known, enter the middle initial. If there is no middle name, leave the field blank.
- The given name as recorded on significant documentation can be used to resolve contradictions. Use reasonable judgment to determine the best choice.
- Given names may include spaces, apostrophe (single quote) and hyphens. No numeric characters are allowed.

Example:
1. Garry D. Richards, Jr. should be entered as Garry D Jr (dropping the period after the middle initial and the abbreviation).

Type: Text (30)

Attribute: *Gender*

Transaction:
Staff Person

See description of the Gender attribute in the Client Demographics transaction.

Gender code “9” (“Unknown”) is acceptable.

Attribute: *Language Code*

Transaction:
Staff Person

Definition:
This code identifies the languages in which a staff person can provide services.

Procedure:
- Enter up to five codes that describe languages in which a staff person can provide services.
- Language code "00" ("Language Unknown") is not acceptable.

Required Documentation:
- Provider records shall document the languages in which a staff person can provide services.

Type: Text (10)

See valid language codes in the Language Code attribute in the Client Demographics transaction.

Transaction: Staff Qualifications

Definition:
Describes the professional qualifications for provider staff.

Required for:
All staff

Procedure:
- Submit on hire and on change.
- Submit at least one transaction for every staff person.
- Submit one transaction for every specialty.

Transaction ID: 660.01

Action Codes:

A	Add
C	Change
D	Delete

Field	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Staff Person ID	Text	10	
Specialty Area	Text	2	Y

Attribute: *Staff Person ID*

Transaction:
Staff Qualifications

Definition:
This uniquely identifies the staff person within an agency who is providing and reporting a service to a client. Where a staff person is also a case manager, the staff ID and the case manager ID should be identical. All staff person IDs should already exist in the MHCADSD system prior to submitting a Staff Qualification transaction. This includes staff id "999", "998", "990".

For mental health specialists agencies must submit the mental health specialty as well as the educational attainment level. For the special '998' staff ID, submit the educational attainment level that your contracted MH specialists would have (typically 25 or 27).

Procedure:
- The staff ID assigned must remain unique to the staff person and cannot be reassigned.

- When the specialist who delivered a service is either a member of another network provider staff or a mental health specialist on sub-contract with the provider, the provider may report the service with either the staff ID of the specialist, or a staff ID of "999" indicating that this is a qualified specialist and not a member of the reporting provider staff, or a staff ID of "998" indicating that this is a special population MH Specialist with one of the following qualifications, as defined under the *qualifications* attribute

    - African American Ethnic Minority MH Specialist
    - Asian/Pacific Islander Ethnic Minority MH Specialist
    - Hispanic Ethnic Minority MH Specialist
    - Native American Ethnic Minority MH Specialist
    - Sexual Minority MH Specialist
    - Other Ethnic Minority MH Specialist

- Staff ID "990" is designated as a team staff ID for reporting per-diem services and services being delivered by a team.

Required Documentation:
The name of the staff person providing services to a client must be documented in provider records.

Type: Text (10)

Attribute: Qualifications

Transaction:
Staff Qualifications

Definition:
This codes the professional staff who meet the requirements for mental health and mental health specialists according to WAC 388-865-0150. See also Section VII, Quality Management.

Procedure:
- Code **each** specialist type for which a clinical staff person qualifies in a separate record.
- If a staff person is a mental health specialist you must submit at least two codes – one identifying the mental health specialty and one identifying the educational attainment level. The educational attainment level will be submitted to DBHR as the provider type in the encounter data. The mental health specialist qualification will be checked by the MHCADSD IS system when a special population evaluation is performed.
- This also describes staff educational attainment levels.

Required Documentation:
Providers must document each specialty area for which a staff person is qualified. For mental health professionals, documentation must include evidence supporting WAC 388-865-0150 or RSN/MHP waiver status 388-865-0265. For mental health specialists, documentation must include the type and amount of training the staff person received in each specialty area, supervision information including hours, name and qualifications of supervisor and span of time supervision was provided. Documentation should include graduation or program completion records for the highest level of educational attainment for each staff person.

Examples:
1. A staff person is qualified both as a geriatric mental health specialist and as an Asian/Pacific Islander Ethnic Minority Health Specialist. Submit two records, one coded 02 and the other 04.
2. A staff person has completed a master degree in counseling and has over two years of experience in mental health care. Code 25.

Type: Text (2)

Valid Codes	Definition	Mapping to State's Provider Type
01	Child Mental Health Specialist [WAC 388-865-0150]	No mapping, but still required by the MHCADSD IS.
02	Geriatric Mental Health Specialist [WAC 388-865-0150]	No mapping, but still required by the MHCADSD IS.
03	African American Ethnic Minority Mental Health Specialist [WAC 388-865-0150]	No mapping, but still required by the MHCADSD IS.

Valid Codes	Definition	Mapping to State's Provider Type
04	Asian/Pacific Islander Ethnic Minority Mental Health Specialist [WAC 388-865-0150]	No mapping, but still required by the MHCADSD IS.
05	Hispanic Ethnic Minority Mental Health Specialist [WAC 388-865-0150]	No mapping, but still required by the MHCADSD IS.
06	Native American Ethnic Minority Mental Health Specialist [WAC 388-865-0150]	No mapping, but still required by the MHCADSD IS.
07	Disability Mental Health Specialist [WAC 388-865-0150]	No mapping, but still required by the MHCADSD IS.
08	Sexual Minority Mental Health Specialist is defined as a mental health professional who: 1. Has completed a minimum of one hundred actual hours of specialized training devoted to a) a broad range of sexual minority issues; and b) effects of culture on mental health. 2. Has the equivalent of one year of full-time direct service with the sexual minority population under the supervision of a mental health professional meeting the criteria of a sexual minority specialist. 3. Can demonstrate cultural competence attained through on-going training or study regarding sexual minority issues totaling 8 to 16 hours per year. (See also Section VII, Quality Management, Attachment B.)	4 – MA/PhD
09	Other Ethnic Minority Mental Health Specialist	No mapping, but still required by the MHCADSD IS.
21	Mental Health Professional: A physician or osteopath licensed under chapter 18.71 or 18.57 RCW, who is board eligible in psychiatry. [WAC 388-865-0150]	3 – Psychiatrist/MD
22	Mental Health Professional: A psychologist licensed under chapter 18.83 RCW. [WAC 388-865-0150]	4 – MA/PhD
23	Mental Health Professional: A registered psychiatric nurse licensed under chapter 18.79 RCW with at least two years' experience in the direct treatment of mentally ill persons and who is an ARNP with prescriptive authority. [WAC 388-865-0150]	2 – ARNP
24	Mental Health Professional: A registered psychiatric nurse licensed under chapter 18.79 RCW with at least two years' experience in the direct treatment of mentally ill persons and who is not an ARNP with prescriptive authority. [WAC 338-865-0150]	1 – RN/LPN

Valid Codes	Definition	Mapping to State's Provider Type
25	Mental Health Professional: A person with at least a master's degree in counseling or one of the social services from an accredited college or university and at least two years' experience in the direct treatment of mentally ill persons. [WAC 388-865-0150]	4 – MA/PhD
26	Mental Health Professional: A mental health counselor or marriage and family therapist licensed under chapter 18.225 RCW with at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a mental health professional, OR a social worker licensed under chapter 18.225.RCW. [WAC 388-865-0150]	4 – MA/PhD
27	Mental Health Professional: A person otherwise qualified to perform the duties of a mental health professional but who does not meet the requirements listed in (a) through (e) of the WAC, where the State has granted an exception to such requirements upon review of a written request by the RSN or MHP involved. [WAC 388-865-0150] [WAC 388-865-0265]	9 – Bachelor Level with Exception/Waiver
28	Certified Consumer Peer Counselor: a consumer of mental health services who has met the educational, experience and training requirements, has satisfactorily passed the examination, and has been issued a certificate by the State Mental Health Division as specified in WAC 388-865-0107.	6 – DOH Credentialed Certified Peer Counselor
29	Peer Support Specialist: A paraprofessional who is a consumer of mental health services (or a parent of a child receiving mental health services) who receives training, supervision (by a mental health professional), and provides support to peers all according to the King County Standards for Peer Support Services.	14 – Non-DOH Credentialed Certified Peer Counselor
31	Certified/Qualified Chemical Dependency Counselor/ Specialist: A *certified* counselor or specialist is a person who has been certified by and has current standing with either the Chemical Dependency Counselor Certification Board or the Northwest Indian Alcohol/Drug Specialist Certification Board. A *qualified* chemical dependency counselor is a person who has provided current documentation that demonstrates all education and experience requirements for WAC 440-22, including continuing education requirements, are met. In addition, all individuals must have a current Department of Health Counselor (DOH) Registration. Interns do <u>not</u> meet this specialty description. Optional.	5 – Below Master's Degree
32	Non Mental Health Professional - RN/LPN	1 – RN/LPN
71	Non Mental Health Professional - M.D.	3 – Psychiatrist/MD
72	Non Mental Health Professional - Ph.D.	4 – MA/PhD

Valid Codes	Definition	Mapping to State's Provider Type
73	Non-Mental Health Professional – Master's	4 – MA/PhD
74	Non-Mental Health Professional - Bachelors	5 – Below Master's Degree
75	Non-Mental Health Professional - Associate	5 – Below Master's Degree
76	Non-Mental Health Professional - High School or GED	5 – Below Master's Degree
77	None of the above	12 – Other

Transaction: Substance Use Frequency

Definition:
Describes how frequently a person has used certain substances during the past month.

Required for:
55, 56, 69, 83, 87

Frequency:
For programs 55, 56, 69:
- Intake Assessment
- Every 12 months after intake
- Discharge

For program 83 (FACT):
- Intake Assessment
- Every six months after intake

For program 87 (FISH):
- Intake Assessment
- Every six months after intake
- Discharge

Transaction ID: 630.01

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Event Date	Text (YYYYMMDD)	8	
Alcohol	Text (number)	1	
Amphetamines	Text (number)	1	
Barbiturates	Text (number)	1	
Benzodiazepines	Text (number)	1	
Cocaine	Text (number)	1	
Hallucinogens	Text (number)	1	
Heroin	Text (number)	1	
Inhalants	Text (number)	1	
Major Tranquilizers	Text (number)	1	

Marijuana-Cannabis	Text (number)	1	
Methamphetamine	Text (number)	1	
Other Sedatives or Hypnotics	Text (number)	1	
Other Opiates and Synthetics	Text (number)	1	
Other	Text (number)	1	
Over the Counter	Text (number)	1	
Oxy/Hydro Codone	Text (number)	1	
PCP	Text (number)	1	
Prescribed Opiate Substitute	Text (number)	1	
Tobacco Products	Text (number)	1	
Authorization Number	Text (number)		
King County ID	Text (number)		

Attribute: *Event Date*

Transaction:
Substance Use Frequency

Definition:
On intake, the event date is the date of assessment as reported in the authorization request.
For six month interval reporting, the event date is every six months after the assessment date.
On discharge, the event date is the date the authorization will end.

Attributes:

Alcohol
Amphetamines
Barbiturates
Benzodiazepines
Cocaine
Hallucinogens
Heroin
Inhalants
Major Tranquilizers
Marijuana-Cannabis
Methamphetamine
Other Sedatives or Hypnotics
Other Opiates and Synthetics
Other
Over the Counter
Oxy/Hydro Codone
PCP
Prescribed Opiate Substitute
Tobacco Products

Transaction:
Substance Use Frequency

Definition:
For each type of substance during the past month, this attribute describes the number of days in a typical week that a person used the particular substance without a prescription or used it abusively with a prescription.

Procedure:
- If the client came directly from jail or hospital, report substance use for the month prior to admission to that setting.
- For each substance, report the number of days from 0 to 7 that the client used the substance.
- A null field will generate a fatal error.

Required Documentation:
The substances used and source of that information shall be documented in the client's clinical record.

Examples:

- At assessment, client reported using alcohol daily and marijuana weekly during the last month. Report 7 for Alcohol and 1 for Marijuana-Cannabis. Submit 0 for all other substance attributes.
- After three months of treatment, the same client, who had denied using cocaine at intake, reported that she had been using cocaine several times a week in the months before she started treatment. Submit a Change transaction for the assessment data to change the Cocaine value from 0 to 3.

Type: Text (1)

Transaction: Vulnerability Assessment Transaction

Definition:
Describes the results of an assessment of a homeless person's functioning in ten life or risk domains; used to prioritize access to housing and supportive services.

Required for: Homeless adults who have had a vulnerability assessment completed using the standardized DESC vulnerability assessment tool, and who have given consent for the assessment results to be submitted to MHCADSD for inclusion in the integrated database that is used to identify high need candidates for housing resources

Frequency:
On referral for shelter or housing. At each 12-month anniversary, if continuing to seek shelter/housing.

Procedure:
- All data for this transaction will be submitted by DESC, including vulnerability assessments performed by other agencies**.**

Transaction ID: 680.01

Action Codes:

A	Add
C	Change
D	Delete

Attribute	Type	Size	Coded
Reporting Unit ID	Text	3	Y
Case ID	Text	10	
Event Date	Text (YYYYMMDD)	8	
Survival Rating	Text (number)	1	Y
Basic Needs	Text (number)	1	Y
Indicated Mortality Risks	Text (number)	1	Y
Medical Risks	Text (number)	1	Y
Organization Orientation	Text (number)	1	Y
Mental Health	Text (number)	1	Y
Substance Use	Text (number)	1	Y
Communication	Text (number)	1	Y
Social Behaviors	Text (number)	1	Y
Homelessness	Text (number)	1	Y
Veteran Status	Text	1	Y
Assessor ID	Text	8	Y
King County ID	Text (number)		

Attribute: *Reporting Unit ID*

Transaction:
Vulnerability Assessment Transaction

Procedure:

- Always submit DESC Agency ID: 152

Attribute: Case ID

Transaction:
Vulnerability Assessment Transaction

Definition:
The unique client identifier in the DESC information system.

Procedure:
- Even if the assessment was done by another agency, submit the DESC Case ID. All clients assessed using the DESC Vulnerability assessment tool and reported to the MHCADSD IS are identified as DESC clients.

Attribute: Event Date

Transaction:
Vulnerability Assessment Transaction

Definition:
The date the assessment was completed.

Attributes for domains assessed:

Survival Rating
Basic Needs
Indicated Mortality Risks
Medical Risks
Organization Orientation
Mental Health
Substance Use
Communication
Social Behaviors
Homelessness

Transaction:
Vulnerability Assessment Transaction

Definition:
See the DESC Vulnerability Assessment Tool for definitions of, and procedures for scoring, the assessment domains.

Attribute: *Assessment Values*

Transaction:
Vulnerability Assessment Transaction

Definition:
Assessment values for the first nine domains are 1 through 5.
Homelessness values are 1 through 3.

Attribute: *Veteran Status*

Transaction:
Vulnerability Assessment Transaction

Definition:
Indicates whether or not the client reported being a military veteran.

Attribute: *Assessor ID*

Transaction:
Vulnerability Assessment Transaction

Definition: An identifier in the MHCADSD system of the person who assessed a client using the Vulnerability Assessment Tool.

Procedure:
- For DESC staff, use the KCID assigned to the person in the MHCADSD system.
- For assessors who are not DESC staff, DESC staff will assign the alphanumeric Assessor ID and report it to the DCHS IT staff. DCHS IT staff will manually update the sud_vul_assessor table**.**

Attribute: *King County ID*

Transaction:
Vulnerability Assessment Transaction

Procedure:
Each reported client should have a KCID. If the person assessed does not have a KCID, DESC will need to submit a Client Demographics transaction with Agency ID '152' to get a KCID assigned.

Transaction: UNIVERSAL ATTRIBUTES AND DEFINITIONS

Attribute: *Case ID*

Definition:
The identifier established by a Reporting Unit which uniquely identifies a client. A case ID should never be recycled to another client.

Type: Char (10)

Valid Codes:
No restrictions. Up to 10 characters may be used.

Attribute: *Event Date*

Definition:
The date an event actually occurred or the date an agency learned of the event or change.

Type: Date (8)
YYYYMMDD

Summary Table of Event Date Reporting Requirements

Transaction	On assessment	On change or occurrence	On discharge	Master table
Activity Evaluation	Assessment Date	Actual Date	N/A	ep_activity
Authorization Request	Assessment Date	Actual Date	N/A	au_master
Client Demographic	Assessment Date	Actual Date		g_person, g_demographic mp_ethnicity client_master
Conditions at Assessment	Assessment Date	N/A	N/A	ma_cond_ass
Co-occurring Disorders Assessment	N/A	Actual Date	N/A	ea_cod_assessment
Co-occurring Disorders Screening	N/A	Actual Date	N/A	ea_cod_screening
CPT Service Detail (submitted in HIPAA 837P transaction)	N/A	Actual Date	N/A	ea_cpt_service ea_cpt_service_modifier mp_mail_address
Diagnosis	Assessment Date	Actual Date	Actual Date	ea_diag
Disability	Assessment Date	Actual Date	N/A	ep_disability ep_subabuse
Income Category	Assessment Date	Actual Date	N/A	ep_income02
Medicaid Coverage	Assessment Date	Actual Date	N/A	ep_medicaid_cov
Notice of Exit	N/A	N/A	Actual Date	ma_notice_of_exit au_master
Outcome Event	N/A	Actual Date	N/A	ea_outcome_event
Priority	Assessment Date	Actual Date	N/A	mp_priority
PSS	Assessment Date	Actual Date	Actual Date	ea_pss
Program Referral	Actual Date	N/A	Actual Date	ma_screen_cont ma_prgm_ref_in ea_prgm_ref_out
Residential Absence	Actual Date	Actual Date	N/A	ep_resid_absence
Residential Arrangement	Assessment Date	Actual Date	N/A	ep_residence ep_address
Residential Facility	Actual Date	Actual Date	N/A	ep_facility
Staff Person	N/A	Actual Start Date	Actual Discharge Date	g_person, g_demographic client_master ep_staff_dur

Definitions for Summary Table:

Assessment Date: The date reported in the Authorization Request transaction as the Assessment Date for Benefit Change Code 01 and 05.

Actual Date: The date the event (e.g., referral, diagnosis, discharge, or change) occurred. This is not the date the change was reported to the clinician. Where unknown, make a best estimate and document the file.

On Discharge: The date of discharge. For system edits, this date must always be within the benefit period.

***NOTE*: The computer system or data entry date should not be entered as the event date unless it really is.**

Attribute: *King County ID*

Transaction:
Universal

Definition:
The unique King County identifier assigned to a person by the MHCADSD IS after the MHP system has unduplicated person records across all data sources.

Procedure:
- This identification number uniquely identifies a client receiving services from the King County MHP, or staff providing services at King County MHP.
- If providers know the client's King County ID, it must be submitted in the authorization request for an outpatient or residential benefit. It is the responsibility of the reporting provider to check the ECLS for the correct King County ID. The KCID is required for all indicated transactions except an initial authorization request and the service detail record for a client not already assigned a KCID.
- This attribute may be null if the provider does not know it for the initial authorization request but must be used in subsequent transactions.

Required Documentation:
The client's KCID must be maintained in the clinical record.

Type: Integer

Attribute: *Reporting Unit ID*

Required for:
Listed entities

Definition:
A code established by the Mental Health Division to uniquely identify an organization delivering services to a client.

Type: Char (5)

Definitions

Initial Assessment: The first assessment of an individual that a provider does for any MHP-funded services.

Index

A

Activity Evaluation, 140, 169, 175, 228
Actual date, 240
Adult Diversion Bed, 14, 153
Adult Long-Term Residential, 14, 153
Adult Supervised Living, 14, 153
Adults Crisis Stabilization, 14, 153
Agency/System, 188
Alcohol, 129
Annual Income, 132
Anxiety Symptoms, 167
Attachment Difficulties, 52
Authorization Number, 18
Authorization Request, 10
Axis I, 95, 125
Axis II, 95, 125
Axis Subtype, 125
Axis V, 96

B

Batch Footer, 20
Batch Header, 21
Benefit Change Code, 15
Benefit/Program Requested, 12

C

Case ID, 237
Case Manager Comment, 25
Case Manager Contract Information, 22
Case Manager ID, 23, 27
Case Manager Link, 26
Case Manager Phone, 24
Catastrophic Tier Change, 16
Child Witness to Violence, 56
Child's Parent(s) Teens, 59
Children's Circumstances, 53
Children's Conditions, 50
Children's Crisis Response, 14, 153
Client Demographics, 32
Cognitive, 167
Cognitive Impairment in Parents, 59
Community Living, 166
Condition Code, 49
Conditions at Assessment, 48, 62
County Code, 203
CPT Code, 72
CPT Service Detail, 68
Crisis Triage Diversion Bed – DESC, 14, 153
CSO Identifier, 135
Cultural or Sexual Minority Status, 59

D

Dangerous Behavior, 166
Dangerous Mentally Ill Offender, 13
data entry date, 240
Date of Birth, 36
DC03 to DSM-IV-TR, 121
Deaf, 128
Death of a Parent, 57
dependence on drugs, 129
Depressive Symptoms, 167
Developmental Disability, 128
Developmental Disorder, 51
Diagnosis, 93
Diagnosis Code, 65, 88, 95, 145
Disability, 126
Dissociative Symptoms, 167
District Mental Health Court, 189
Divorce/Separation, 57
Domestic Violence, 56
Drug, 129

E

Education Status, 7
Employment Status, 5
End Date, 212
EPSDT Indicator, 76
Ethnicity, 37
Event Date, 70, 155, 184, 185, 238
Exit Code, 157
Expiration with no renewal, 157

F

Facility Code, 196, 208
Family Discord, 54
Family Size, 132, 133
federal poverty level, 133
Federal Poverty level, 132
Fetal Alcohol Syndrome, 50
First day of assessment, 240

G

Gender, 35, 215
Geriatric Crisis Response, 13, 152
Given Names, 34, 214
Grade Level, 9

H

Harassment or Abuse by Peers, 59
Hard of hearing, 128
Health Problems in Parents, 58
Health Status, 167
Hispanic Origin, 39
Homelessness, Adults, 60
Homelessness, Children, 60
HOST Intensive Case Management, 13, 152
HOST Outreach, 13, 152

I

Impairment Kind, 73, 127
Inadequate Parenting, 55
Income Category, 130, 131
Initial tier change, 16
Inpatient, 14
Interpreter required, 40

K

King County ID, 47, 241

L

Language Code, 41
Law Breaking Behavior in Child, 51
Learning Disability, 51
Linkage Indicator, 191

M

Medicaid Coverage, 134
Medical Necessity Criteria, 12
Medically compromised, 128
Medicare Indicator, 136, 137
Mental Illness in Parents, 58
Minutes of Service, 74
MIO/CTP, 13, 22, 152
Multiple Moves, 60
Municipal Mental Health Court, 189

N

Negative Social Behavior, 166
Neurological Condition, 50
Next benefit, 16
No normative activity, 8
Notice of Exit, 151

O

On Discharge, 240
Other Activity Code, 8
Out of County, 202
Out-of-Home Placement, 54
Outpatient, tier 2X, 13, 152
Outpatient, tier 3A, 13, 152
Outpatient, tier 3B, 13, 152

P

Parents Involvement in Criminal Justice System, 58
Physical, 166
Physical Abuse, 55
Primary Case Manager, 23
primary focus of treatment, 125
Problem Severity Summary, 28, 163
Program Referral, 183
Program Type, 186
Provider change, 16
PSS, 28, 163
Psychotic Symptoms, 167

Q

Qualifications, 219

R

Refugee or Immigrant, 61
Reporting Unit ID, 242
Request Date, 17
Residential Absence, 192
Residential Arrangement, 197
Residential Arrangement Code, 199
Residential Facility, 205
Response to Stress, 166
Risk Indicators, 61

S

Screening Contact, 185
Self-Care, 166
Sensory or communication, 128

Seriously Behaviorally Disturbed, 51
Service Location, 75
Service Transaction ID, 71
Sexual Abuse, 56
Sexual Minority Status, 43, 44
Social Withdrawal, 166
Socio-Legal, 166
Staff Person Provider ID, 77
Staff Person, 209
Staff Person ID, 23, 78, 210, 218
Staff Qualifications, 217
Start Date, 193, 198, 206, 211
Substance Abuse, 129
Substance Abuse in a Child, 51
Substance Abuse in Parents, 58
Suicidal Behavior in a Parent, 57
Summary Table of Event Date Reporting Requirements, 239
Surname, 33, 213
Sustained Attention, 166

T

Team, 19
Team Service Flag, 19
Teen Parenthood or Pregnancy, 59
Termination, 157
Third Party Coverage Indicator, 138
Title XIX, 135
Troubled Sibling, 57

U

UNIVERSAL ATTRIBUTES, 237

V

Visual disability, 128

X

XE Cancellation, 157

Z

Zip code, 78, 80, 81, 82, 83, 84, 85, 86, 202

MHCADSD and KCMHP Providers HIPAA Trading Partner Agreement

The Health Insurance Portability and Accountability Act (HIPAA) requires that King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD), and all other covered entities in the United States, comply with National Electronic Data Interchange standards for health care transactions as established by the Secretary of Health and Human Services (HHS). The HIPAA Implementation Guides have been established as the standards of compliance for health care transactions. The Implementation Guide and Addenda to the Guide for each transaction are available at www.wpc-edi.com.

HIPAA suggests that it is appropriate and prudent for payers to develop a trading partner agreement as a companion document to the standard HIPAA Implementation Guides. This is because there are two levels of scrutiny that all electronic transactions must go through. First is the standard compliance and second is the specific processing, or adjudication, of the transactions in each trading partner's individual system. Since this processing will vary from site to site (e.g., payer to payer), additional documentation that gives information regarding the processing of the transaction will prove helpful to each site's trading partners (e.g., providers) and will simplify implementation.

It is important that the trading partner agreement NOT:

- Modify the definition, condition, or use of a data element or segment in the standard Implementation Guide;
- Add any additional data elements or segments to the standard;
- Utilize any code or data values which are not valid (because they are either marked "not used" in the Guide or they are not in the standard X12 transaction at all); or
- Change the meaning or intent of the standard Implementation Guide.

This Trading Partner Agreement is intended to serve only as a companion document to the HIPAA Implementation Guides. The use of this document is for the purpose of clarification only and does not contradict any requirements in the Implementation Guides. Specifically, where the Implementation Guides allow trading partners to make a choice, this document specifies the data elements and values to use in a standard HIPAA transaction.

The detailed Trading Partner Agreement has been developed and is included as a separate attachment.

Note: Only one of the HIPAA transactions, the Health Care Claim 837 Professional transaction, is necessary for providers to report outpatient and crisis service data to MHCADSD. One other potential transaction, the Eligibility Inquiry/Response 270/271 transaction, might be available to providers from DCHS Medical Assistance Administration. This Trading Partner Agreement pertains only to the 837 Professional transaction and does not cover the 270/271 Eligibility transaction.

MHCADSD and KCMHP
Provider Trading Partner Agreement
837 HEALTH CARE CLAIM PROFESSIONAL TRANSACTION

Segment ID	Loop/Seg. Name	Usage	Loop/Segment Repeat	Element Name	Usage	Example	Recomm. Values	Comments
ISA	**INTERCHANGE CONTROL HEADER**	**R**	**1**	Authorization Information Qualifier	Req	ISA*00*0123456789*00*9876543210*ZZ*	00	
				Authorization Information	Req	022 *ZZ*411 *		
				Security Information Qualifier	Req	020920*1930*U***00501***900000001*0*P*:~	00	
				Security Information	Req			
				Interchange ID Qualifier	Req		ZZ	
				Interchange Sender ID	Req		<RUID>	3 digit Reporting Unit ID (019, 022, etc.)
				Interchange ID Qualifier	Req		ZZ	
				Interchange Receiver ID	Req		411	Reporting Unit ID for KCMHCADSD
				Interchange Date	Req			
				Interchange Time	Req			
				Interchange Control Standards Identifier	Req			
				Interchange Control Version Number	Req		00501	
				Interchange Control Number	Req			
				Acknowledgment Requested	Req		0	
				Usage Indicator	Req		P, T	Use P for production, T for testing
				Component Element Separator	Req		:	
GS	**FUNCTIONAL GROUP HEADER**	**R**	**1**	Functional Identifier Code	Req	GS*HC*022*411*20020920*1930*700000001*		
				Application Sender's Code	Req	X***005010X222A1***~	<RUID>	3 digit Reporting Unit ID (019, 022, etc.)
				Application Receiver's Code	Req		411	Reporting Unit ID for KCMHCADSD
				Date	Req			
				Time	Req			The recommended format is HHMM
				Group Control Number	Req			
				Responsible Agency Code	Req			
				Version / Release / Industry Identifier Code	Req		005010X222A1	
ST	**Transaction Set Header**	R	1	Transaction Set Identifier Code	Req	ST*837*000001*005010X222A1~		
				Transaction Set Control Number	Req			
				Implementation Convention Reference	Req		005010X222A1	
BHT	Beginning of Hierarchical Transaction	R	1	Hierarchical Structure Code	Req	BHT*0019*00*02216749*20020920*0932*RP~		
				Transaction Set Purpose Code	Req			
				Reference Identification	Req			The value will be used as a Batch Number
				Date	Req			
				Time	Req			The recommended format is HHMM
				Transaction Type Code	Req		RP	Use RP since ST-SE envelope only contains encounters.
	1000A - SUBMITTER NAME	**R**	**1**					
NM1	Submitter Name	R	1	Entity Identifier Code	Req	NM1*41*2*COMMUNITY PSYCHIATRIC CLINIC*****46*022 ~		
				Entity Type Qualifier	Req			
				Name Last / Organization Name	Req			
				Name First	Sit			

				Name Middle	Sit			
				Identification code Qualifier	Req		46	
				Identification code	Req		<RUID>	3 digit Reporting Unit ID (019, 022, etc.)
PER	Submitter EDI Contact Information	R	2	Contact Function Code	Req	PER*IC*LISA*TE*2065452384~		
				Name	Req			
				Communication Number Qualifier	Req		TE	
				Communication Number	Req			
				Communication Number Qualifier	Sit			
				Communication Number	Sit			
				Communication Number Qualifier	Sit			
				Communication Number	Sit			
	1000B - RECEIVER NAME	**R**	**1**					
NM1	Receiver Name	R	1	Entity Identifier Code	Req	NM1*40*2*KC MHCADSD IS*****46*411~		
				Entity Type Qualifier	Req			
				Name Last / Organization Name	Req			
				Identification code Qualifier	Req			
				Identification code	Req		411	Reporting Unit ID for KCMHCADSD
	2000A - BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL	**R**	**>1**					
HL	Billing/Pay-to Provider Hierarchical Level	R	1	Hierarchical Id Number	Req	HL*1**20*1~		
				Hierarchical Level Code	Req			
				Hierarchical Child Code	Req			
PRV	Billing/Pay-To Provider Specialty Information	S	1	PRV Provider Code	Req	PRV***BI*PXC***251400000X ~	BI	Required when adjudication is known to be impacted by the provider taxonomy code, and the Rendering Provider is the same entity as the Billing and/or Pay-to Provider.
				Reference Identification Qualifier	Req		PXC	
				Reference Identification	Req			Provider Taxonomy Code
	2010AA — BILLING PROVIDER NAME	**R**	**1**					
NM1	Billing Provider Name	R	1	Entity Identifier Code	Req	NM1*85*2*COMMUNITY PSYCHIATRIC CLINIC*****XX*1112223444 ~		If "code XX - NPI" is used in the NM108/09 of this loop, then either the Employer's Identification Number or the Social Security Number of the provider must be carried in this REF
				Entity Type Qualifier	Req			
				Name Last / Organization Name	Req			
				Name First	Sit			
				Name Middle	Sit			
				Name Suffix	Sit			
				Identification code Qualifier	Req		XX	
				Identification code	Req			National Provider Identifier
N3	Billing Provider Address	R	1	Address Information	Req	N3*4319 STONE WAY NORTH~		
				Address Information	Sit			
N4	Billing Provider City/State/Zip Code	R	1	City Name	Req	N4*SEATTLE*WA*98103~		
				State or Providence Code	Req			
				Postal Code	Req			
				Country Code	Sit			
REF	Billing Provider Secondary Identification	R	1	Reference Identification Qualifier	Req	REF*EI*91-2223456	EI	Employer's Identification Number

				Reference Identification	Req			
	2000B - SUBSCRIBER HIERARCHICAL LEVEL	**R**	>1					
HL	Subscriber Hierarchical Level	R	1	Hierarchical Id Number				
				Hierarchical Parent ID Number	Req			
				Hierarchical Level Code	Req	HL*2*1*22*0~		
				Hierarchical Child Code	Req		0	Use 0 since patient is always a subscriber
SBR	Subscriber Information	R	1					
				Payer Responsibility Sequence # Code	Req		P	Required when the subscriber is the same person as the patient.
				Individual Relationship Code	Sit	SBR*P*18*******MC~		
				Reference Identification	Sit			
				Name	Sit			
				Claim Filing Indicator Code	Sit(R)		MC, ZZ	Required prior to mandated use of PlanID. Use MC for Medicaid clients, ZZ for others.
	2010BA - SUBSCRIBER NAME		1	Claim Filing Indicator Code				
NM1	Subscriber Name	R	1		Req			
				Entity Identifier Code	Req			
				Entity Type Qualifier	Req			
				Name Last / Organization Name	Req			Required if NM102=1 (person).
				Name First	Sit	NM1*IL*1*DOE*JOHN*T**SR*MI*23097~		
				Name Middle	Sit			
				Name suffix	Sit			
				Identification Code Qualifier	Req		MI	Required if NM102=1 (person).
				Identification code	**Req**		<KCID>	Required if NM102=1 (person). Use KCID as a Member Identification Number
N3	Subscriber Address	S(R)	1	Address Information	Req	N3*UNKNOWN~		Required if the patient is the same person as the subscriber.
				Address Information	Sit			Required if a second address line exists.
N4	Subscriber City/State/Zip code	S(R)	1	City Name	Req	N4*SEATTLE*WA*98101~		Required if the patient is the same person as the subscriber.
				State or Province Code	Req			
				Postal Code	Req			
				County Code	Sit			
DMG	Subscriber Demographic Information	S(R)	1	Date Time Period format Qualifier	Req	DMG*D8*19430501*M~		subscriber.
				Date Time Period (DOB)	Req			(Required when Loop ID-2000B, SBR02=18 (self)).
				Gender Code	Req		F, M	
	2010BB - PAYER NAME	**R**	**1**		Req			
NM1	Payer Name	R	1	Entity Identifier Code	Req	NM1*PR*2*KC MHCADSD IS*****PI*411~	PR	
				Entity Type Qualifier	Req		2	
				Name Last / Organization Name	Req			KC MHCADSD IS
				Identification code Qualifier	Req		PI	
				Identification code			411	Reporting Unit ID for KCMHCADSD
	2300 - CLAIM INFORMATION	**R**	**100**					
CLM	Claim Information	R	1	Claim Submitter's Identifier	Req			

				Monetary Amount	Req	CLM*3*0***56:**B**:1*Y*A*Y*Y*P~		
				Not Used				
				Not Used				
				Information	Req			
				Facility Code Value	Req			
				Facility Code Qualifier	**Req**			
				Claim Frequency Type Code	Req			1 = Add; 6 = Change; 7 = Change; 8 = Delete
				Yes/No Condition or Response Code	Req		Y	
				Provider Accept Assignment Code	Req		A	
				Yes/No Condition or Response Code	Req		Y	
				Release of Information Code	Req		Y	
				Patient Signature Source Code	Req			
REF	**Prior Authorization**		1	Reference Identification Qualifier	Req	REF*G1*422813~		
				Prior Authorization	Req		<Authoriz. # >	Use Authorization Number
HI	Health Care Diagnosis Code	S(R)	1	Health Care Code Information	Req	HI*BK:29530~		Required on all claims/encounters except claims for which there are no diagnoses (e.g., taxi claims).
				Code List Qualifier Code (Diagnosis Type Code)	Req		BK	Health CareCode Information data element can be repeated 8 times
				Industry Code (Diagnosis Code)	Req			Only primary diagnosis is required.
	2310C SERVICE FACILITY LOCATION	**S**	**1**		Req			This loop is required when the location of health care service is different than that carried in the 2010AA (Billing Provider) loop.
NM1	Service Facility Location	S	1	Entity Identifier Code	Req	NM1*77*2*EL REY TREATMENT FACILITY*****XX*1112223444~		If "code XX - NPI" is used in the NM108/09 of this loop, then either the Employer's Identification Number or the Social Security Number of the provider must be carried in this REF
				Entity Type Qualifier	Req			
				Name Last / Organization Name	Req			
				Identification code Qualifier	Req			
				Identification Code	Req			National Provider Identifier
N3	Service Facility Location Address	R	1	Address Information	Req	N3*2119 2ND AVENUE ~		
				Address Information	Sit			
N4	Service Facility Location City/State/Zip code	R	1	City Name	Req	N4*SEATTLE *WA*98121~		
				State or Province Code	Sit			
				Postal Code	Sit			
				County Code	Sit			
	2400 - SERVICE LINE		**50**		Req			
LX	Service Line	R	1	Assigned Number	Req	LX*1~		
SV1	Professional Service	R	1	Composite Medical Procedure Identifier	Req			
				Product/Service ID Qualifier	Req		HC	
				Product/Service ID	Req			Any valid CPT/HCPCS code
				Procedure Modifier	Sit		HE, HH, HK, UA, UC	Use this modifier for the first procedure code modifier. Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.

				Procedure Modifier	Sit	SV1*HC:90804:UC*0*MJ*90***1****Y~		Use this modifier for the second procedure code modifier. Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.
				Procedure Modifier	Sit			Use this modifier for the third procedure code modifier. Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.
				Procedure Modifier	Sit			Use this modifier for the fourth procedure code modifier. Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.
				Description	Sit	SV1*HC:90804:UC:::016|118*0*MJ*90***1****Y~		Use this to report Evidence Based Practices that were employed in delivery of this service. Multiple codes should be delimited with a pipe ('|') symbol. See the DBHR Service Encounter Reporting Instructions (SERI) "Evidence Based Practice - Children's Mental Health" section for instructions and valid codes.
				Monetary Amount	Req		0	
				Unit or Basis for Measurement Code	Req		MJ	
				Quantity	Req			
				Facility Code Value	Sit			Required if value is different than value carried in CLM05-1 in Loop ID-2300.
				Composite Diagnosis Code Pointer	Req			Required if HI segment in Loop ID-2300 is used. Only one pointer (for primary diagnosis) is required
				Yes/No Condition or Resp. Code (Emergency Indicator)	Sit		Y, NULL	Required if Medicaid services are the result of emergency services
				Yes/No Condition or Resp. Code	Sit		Y, NULL	Required if Medicaid services are the result of a screening referral.
DTP	Date - Service Date	R	1	Date/time Qualifier	Req	DTP*472*D8*2002091~		
				Date Time Period Format Qualifier	Req		D8	
				Date Time Period				
REF	Line Item Control Number	R	1	Reference Identification Qualifier	Req	REF*6R*683741	6R	The Reference Identification element contains the Service Transaction ID which is a unique reference number generated by your system for each service line.
				Reference Identification	Req			
REF	Referral Number	S	1	Reference Identification Qualifier	Req	REF*9F*683740	9F	Systems that submit multiple encounters per claim must use this segment to associate add-on codes with the primary service. The Reference Identification represents the Service Transaction ID of the primary service.
				Reference Identification	Req			
	2420A - RENDERING PROVIDER NAME	**S(R)**	**1**					The loop is used to identify the staff person providing the service
NM1	Rendering Provider Name	R	1	Entity Identifier Code	Req	NM1*82*2*COMMUNITY PSYCHIATRIC CLINIC*****XX*1112223444~	82	
				Entity Type Qualifier	Req		2	
				Name Last or Organization Name	Req			
				Identification Code Qualifier			XX	
				Identification Code	Req			National Provider Identifier
PRV	Rendering Provider Specialty Information	S	1	Provider Code	Req	PRV*PE***PXC***261QM0801X		
				Reference Identification Qualifier	Req		PXC	The segment became Situational according to Addenda
				Reference Identification	Req			
REF	Rendering Provider Secondary Identification	R	5	Reference Identification Qualifier	Req	REF***G2***159570 ~	**G2**	Provider Commercial Number
				Secondary Identifier				Staff Person KCID

	2420C SERVICE FACILITY LOCATION	S	1					Required when the location of health care service for this service line is different than that carried in the 2010AA, 2010AB or 2310D loops
NM1	Service Facility Location Name Information	S	1	Entity Identifier Code	Req	NM1*77*2*EL REY TREATMENT FACILITY*****XX*1112223444~	77	
			:1	Entity Type Qualifier	Req			Either the Employer's Identification Number or the National Provider Identifier must be carried in this REF
				Name Last / Organization Name	Req			
				Identification code Qualifier	Req		XX	
				Identification code	Req			National Provider Identifier
N3	Service Facility Location Address	R	1	Address Information	Req	N3*2119 2ND AVENUE ~		
				Address Information	Sit			
N4	Service Facility Location City/State/Zip code	R	1	City Name	Req	N4*SEATTLE *WA*98121~		
				State or Province Code	**Req**			
				Postal Code	**Req**			
				County code	**Req**			
SE	**Transaction Set Trailer**	R	1	Number of Included Segments	Req	SE*74*000001~		
				Transaction Set Control Number	Req			
GE	**FUNCTIONAL GROUP TRAILER**	R	**1**	Number of Included Functional Groups	Req	GE*76*700000001~		
				Group Control Number	Req			
IEA	**INTERCHANGE CONTROL TRAILER**	R	**1**	Interchange Control Number	Req	IEA*1*900000001~		

King RSN Service Encounter Reporting Instructions

These instructions supplement the Department of Social and Health Services (DSHS) Division of Behavioral Health and Recovery Service Encounter Reporting Instructions for RSNs, effective July 1, 2013, that instruct RSNs and contracted providers on reporting service encounters for individuals who are served through the Washington state public mental health system. This document only applies to providers that contract with, and submit mental health service encounter data to, the King County Mental Health Chemical Abuse and Dependency Services Division (MHCADSD).

CONTENTS

Benefits for which Supported Employment Services are not accepted by King RSN .....
Collateral Contacts.....
Paraprofessional Peer Support Services.....
Service after Incarceration or Hospitalization .....
Services in the State DSHS Instructions not accepted by King RSN.....
Services included in the State DSHS Instructions, but not accepted by King RSN .....
Instructions for Reporting the Child and Family Team Meeting Service Encounter .....

Benefits and Programs for which Supported Employment Services are not accepted by King RSN

These Supported Employment services will not be accepted for benefits or programs that are funded with Medicaid dollars:

H2023 – Supported employment
H2025 – Ongoing supports to maintain employment

The benefits and programs for which Supported Employment Services may not be reported are:

Benefit or Program Code	Definition
2X1	Outpatient Benefit with 2Xcase rate
3A1	Outpatient Benefit with 3Acase rate
3B1	Outpatient Benefit with 3B case rate
40	Adult Crisis Stabilization (including next day appointment)
71	Adult Long-Term Rehabilitation Benefit
72	Adult Supervised Living Benefit
372	Intensive Supportive Housing Benefit
373	Standard Supportive Housing Benefit

Collateral Contacts

MHCADSD has designated a modifier (UK) to indicate that a service was a collaborative contact with a person from another service system that was made on behalf of the client. For adults, the contact may have been with a person who is a natural support or who is from another service system. The UK modifier is defined as: “Service on behalf of the client to someone other than the client (collateral relationship)”. The UK modifier should be used to indicate Collateral Contacts for all age groups. It is used for Recovery Incentive measures for children and for older adults.

Please note that the CPT codes you submit should match the service that you deliver. This means, for example, that code H2015 (Comprehensive community support services) should NOT be submitted for a family therapy service that is clearly better described by one of the codes for the Family Treatment modality (90846 – Family psychotherapy without patient present, or 90847 – Family psychotherapy with patient present), or for a medication management service better described by one of the codes for that modality. If there is some collateral contact that is a part of such an encounter, the chart note should reflect that and you may add the UK modifier, which will be counted for the Recovery Incentive measure.

Note: MHCADSD will drop the "UK" modifier when service encounter data is sent to the state.

The table below lists all CPT/HCPCS codes for which a UK modifier will be accepted.

CPT/HCPCS codes for which a UK modifier is permissible	
Individual Treatment Services	
	90832 – PSYCHOTHERAPY PATIENT &/ FAMILY 30 MINUTES
	90833 – PSYCHOTHERAPY PT&/FAMILY W/E&M SRVCS 30 MIN
	90834 – PSYCHOTHERAPY PATIENT &/ FAMILY 45 MINUTES
	90836 – PSYCHOTHERAPY PT&/FAMILY W/E&M SRVCS 45 MIN
	90837 – PSYCHOTHERAPY PATIENT &/ FAMILY 60 MINUTES
	90838 – PSYCHOTHERAPY PT&/FAMILY W/E&M SRVCS 60 MIN
	99241 – OFFICE CNSLT NEW/ESTAB MINOR 15 MIN
	99242 – OFC CNSLT NEW/EST LOW SEVER 30 MIN
	99243 – OFFICE CNSLT NEW/ESTAB MOD 40 MIN
	99244 – OFC CNSLT NEW/ESTAB MOD-HI 60 MIN
	99245 – OFC CNSLT NEW/ESTAB MOD-HI 80 MIN
	H0004 – BEHAVIORAL HEALTH CNSL&TX-15 MIN
	H0036 – CMTY PSYC SUPP TX FCE-TO-FCE-15 MIN
	H2014 – SKILLS TRAIN AND DEV, 15 MIN
	H2015 – COMP COMM SUPP SVC, 15 MIN
Intake	
	90791 – PSYCHIATRIC DIAGNOSTIC EVALUATION
	90792 – PSYCHIATRIC DIAGNOSTIC EVAL W/MEDICAL SERVICES
	99201 – OFC/OUTPT E&M NEW MINOR 10 MIN
	99202 – OFC/OUTPT E&M NEW LOW-MOD 20 MIN
	99203 – OFC/OUTPT E&M NEW MOD-SEVER 30 MIN
	99204 – OFC/OUTPT E&M NEW MOD-HI 45 MIN
	99205 – OFC/OUTPT E&M NEW MOD-HI 60 MIN
	99304 – E&M ANNUAL NRS FAC
	99305 – E&M ANNUAL NRS FAC
	99306 – E&M ANNUAL NRS FAC
	99324 – New PT. Dom'y/Rest Home Care (SF)
	99325 – New PT. Dom'y/Rest Home Care (LC)

CPT/HCPCS codes for which a UK modifier is permissible	
	99326 – New PT. Dom'y/Rest Home Care (MC-Detailed)
	99327 – New PT. Dom'y/Rest Home Care (MC-Comprehensive)
	99328 – New PT. Dom'y/Rest Home Care (HC)
	99341 – HOME VISIT E&M NEW PT LO SEV-20 MIN
	99342 – HOME VISIT E&M NEW PT MOD SEV-30 MN
	99343 – HOME VISIT E&M NEW PT MOD-HI-45 MIN
	99344 – HOME VISIT E&M NEW PT HI SEV-60 MIN
	99345 – HOME VISIT E&M NEW PT UNSTBL-75 MIN
	H0031 – MENTAL HEALTH ASSESS NON-PHYSICIAN
Medication Management	
	99211 – OFC/OUTPT E&M ESTAB 5 MIN
	99212 – OFC/OUTPT E&M ESTAB MINOR 10 MIN
	99213 – OFC/OUTPT E&M ESTAB LOW-MOD 15 MIN
	99214 – OFC/OUTPT E&M ESTAB MOD-HI 25 MIN
	99215 – OFC/OUTPT E&M ESTAB MOD-HI 40 MIN
	99307 – Subsequent Nursing Facility Care (SF)
	99308 – Subsequent Nursing Facility Care (LC)
	99309 – Subsequent Nursing Facility Care (MC)
	99310 – Subsequent Nursing Facility Care (HC)
	99334 – Est. PT. Dom'y/Rest Home Care (SF)
	99335 – Est. PT. Dom'y/Rest Home Care (LC)
	99336 – Est. PT. Dom'y/Rest Home Care (MC)
	99337 – Est. PT. Dom'y/Rest Home Care (HC)
	99347 – HOME VISIT E&M ESTAB MINOR-15 MIN
	99348 – HOME VISIT E&M ESTAB LOW-MOD 25 MIN
	99349 – HOME VISIT E&M ESTAB MOD-HI 40 MIN
	99350 – HOME VISIT E&M ESTAB MOD-HI 60 MIN
	M0064 – BRF OV MON/CHANG RX -TX MENTL D/O
	T1001 – NURSING ASSESSMENT/EVALUATION
Medication Monitoring	
	H0034 – MEDICATION TRN&SUPPORT PER 15 MIN
Family Treatment	
	90846 – FAMILY PSYCHOTHERAPY WO PT PRS
	90847 – FAMILY PSYCHOTHERAPY W/PT PRS
Crisis Services	
	H2011 – CRISIS INTERVEN SVC, 15 MIN

Paraprofessional Peer Support Services

The MHCADSD system includes two different staff qualifications related to peer support:

28: Certified Consumer Peer Counselor
29: Peer Support Specialist

These MHCADSD staff qualifications map to state provider types as follows:

28: Certified Consumer Peer Counselor	→	06: DOH Credentialed Certified Peer Counselor
29: Peer Support Specialist	→	14: Non-DOH Credentialed Certified Peer Counselor

Therefore, a "28: Certified Consumer Peer Counselor" can report all services listed in the DBHR Service Encounter Reporting Instructions (SERI) with a provider type of "06: DOH Credentialed Certified Peer Counselor."

Likewise, a staff member with the "29: Peer Support Specialist" qualification can report all services listed in the DBHR Service Encounter Reporting Instructions (SERI) with a provider type of "14: Non-DOH Credentialed Certified Peer Counselor."

In addition, a peer counselor can also report services that are allowable based on their educational level. Because of this, you should use the Staff Qualifications transaction to identify the type of peer counselor and their educational level. In other words, you will send in two different staff qualifications for the same staff person. Below is a listing of how the MHCADSD educational qualifications map to the state provider types:

73: Non-Mental Health Professional – Masters	→	04: MA/PhD
74: Non-Mental Health Professional – Bachelors	→	05: Below Master's Degree
75: Non-Mental Health Professional – Associate	→	05: Below Master's Degree
76: Non-Mental Health Professional – High School or GED	→	05: Below Master's Degree

As an example, if the peer counselor has a bachelor's degree then all services listed in the DBHR Service Encounter Reporting Instructions (SERI) with the "05: Below Master's Degree" provider type are reportable.

Service data for services provided by Peer Support Specialists or Certified Consumer Peer Counselors will be used for a recovery incentive measure. As stated above, it is expected that more than one staff qualification will be set up in our system for these staff – if any one of the qualifications is "28: Certified Consumer Peer Counselor" or "29: Peer Support Specialist" we assume the person is providing peer support, and all reported services are assumed to be in the delivery of peer support (including those only allowable based on their educational credentials).

Note that interpreter services (code T1013) are not included in the recovery incentive measure because they are an adjunct to the primary service that is being provided.

Service after Incarceration or Hospitalization

For the measurement services provided within seven days (before or after) of release from incarceration or discharge from hospitalization, MHCADSD will restrict the services that count to the same ones that the state is using for their similar measure – with one addition to the list: the MHCADSD-defined "collateral contact" services (H2015 – UK) will also be excluded.

Services before the release/discharge date will only be counted if they have a "service location" that indicates the provider delivered the service in the jail (code 09) or hospital (code 51). (Services cannot be before the booking or admission date.)

These data are used for a recovery incentive measure.

The following CPT/HCPCS Code and modifier combinations will be excluded. (Old, inactive codes are shown to document exclusions that would apply to older data.)

Service (previously "Modality")	**Description**	**Codes**	**Modifier**
Crisis Services	Old crisis services codes (not accepted for services after 12/31/06)	99281-99285	None
	Crisis hotline	H0030	None UC UD
	Crisis intervention	H2011	None, UC UD
Request for Mental Health Services	Request for mental health services (with "UD" modifier)	H0046	UB (required) UD (optional)
Brief Intervention Treatment	Family therapy without patient	90846	UA
Community Psycho-education & Prevention	Behavioral health prevention information	H0024	None
Co-Occurring Disorder Treatment	Family therapy without patient	90846	HH
Family Treatment	Family therapy without patient	90846	None
Individual Treatment Services	Preparation of report of patient's psychiatric status, history, treatment, or progress	90889	None, UD
	Comprehensive community support services - collaborative contact with a representative of another service system with which the consumer is involved (MHCADSD exclusion; not DSHS exclusion)	H2015	UK (start date: 8/1/08) **{Services without this modifier are included}**
	[Old code] Mental health service, not otherwise specified (not accepted for services after 12/31/06)	H0046	None
Integrated Substance Abuse Mental Health Assessment	Alcohol/Drug Assessment	H0001	HH (required), UD (optional)
Integrated Substance Abuse Mental Health Screening	Initial screening to determine possible chemical dependency and mental health treatment needs utilizing the GAIN-SS	H0002	HH (required), UD (optional)
Interpreter Services	Sign or oral interpretive services	T1013	None UD
Involuntary Treatment Investigation	Crisis intervention	S9484	None, UC UD

Service (previously "Modality")	Description	Codes	Modifier
Psychological Assessment	Psychological testing (includes report writing)	96101-96103	None UD
	Developmental testing (includes report writing)	96110-96111	None UD
	Neurobehavioral status exam	96116	None UD
	Neuropsychological testing (includes report writing)	96118-96120	None UD
	Old code: Assessment of aphasia	96105	None
Respite Care Services	Respite services, in-home (per diem)	S9125	None UD
	Respite services, out of home (per diem)	H0045	None UD
	Respite services (minutes)	T1005	None UD
Special Population Evaluation	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol	T1023	HE (required) UD
Rehabilitation Case Management	Behavioral health outreach service	H0023	None UD

Modifiers:

UA: Used to indicate brief intervention treatment (applies to many codes)
UB: Used to indicate that "H0046" describes request for mental health services
UC: Used to indicate service provided by multiple staff for safety purposes (H2011, H0036, S9484 only)
UD: WA-PACT service (applies to many codes)
UK: Used by King RSN to indicate that "H2015" describes a collateral contact with a representative of another service system *
H9: Medical testimony provided as part of an involuntary treatment service (99075 only)
HE: Mental health program (T1023 only)
HH: Mental health/substance abuse program (applies to H0002, H0001 and limited individual, family and group therapy codes)

* The standard description of UK is "Services provided on behalf of the client to someone other than the client (collateral relationship)"

Services included in the State DSHS Instructions, but not accepted by King RSN

The following services that are included in the DSHS Service Encounter Reporting Instructions are not accepted by King RSN.

Service (previously "Modality")	Description	Codes	Modifier
Freestanding Evaluation and Treatment Services	Psychiatric health facility service	H2013	None
High Intensity Treatment	Multi-systemic therapy, children	H2033	None

Instructions for Reporting the Child and Family Team Meeting Service Encounter

These are the King County instructions for reporting the Child and Family Team Meeting Service encounter introduced in the November 1, 2012 revision of the State Encounter Reporting Instructions (SERI).

Code H0032: Mental Health Service Plan development without physician

With Modifier: HT Multidisciplinary Team

1. Report for children/youth (up to age 21) enrolled in a current outpatient benefit (Medicaid or MIDD funded) at your agency, and, when a CFT that meets the SERI definition is being facilitated by your agency on behalf of this child.
2. Report this service every time the CFT meets.
3. Report this service only for the child/youth who has the outpatient authorization/benefit (even if there are other children or family members present).
4. Only one staff person may report the encounter, although other staff may be participating in the CFT meeting.
5. The staff reporting the service must be an MHP or be supervised by an MHP.
6. Note that under the definition of a CFT, any member of the team may "facilitate" CFT meetings. It will be the agency's responsibility to designate which agency staff involved in a CFT will report that service encounter.

Exclusions:

1. Do not report CFT services if the child is participating in MIDD Wraparound (program code 107) or Family Treatment Court Wraparound (program code 108) through your agency.
2. Do not report CFT services if staff from your agency participate as the mental health provider on a CFT that is facilitated by one of the five Wraparound Delivery Teams operated by Sound Mental Health, Valley Cities Counseling and Consultation, Center for Human Services, Therapeutic Health Services or Community Psychiatric Clinic.
3. Do not report CFT services if staff from your agency participate as the mental health provider on a CFT that is facilitated by another system (e.g., DCFS, DDD, juvenile justice, schools, etc.).

XIII. PRIVACY AND SECURITY OF INFORMATION SYSTEMS DATA AND CLIENT RECORDS

1.0 POLICY TITLE: PRIVACY AND SECURITY OF INFORMATION SYSTEMS DATA AND CLIENT RECORDS

1.1 Originally Implemented: December 1, 1993

1.2 Reviewed and revised: November 2014

1.3 Officially Adopted: January 2, 2015

1.4 Effective Date: February 2, 2015

1.5 Signed: _____
Jean Robertson, Assistant Division Director,/RSN Administrator

2.0 PURPOSE: To describe the requirements for safeguarding information systems, data security, and the protection of client records and confidentiality.

3.0 POLICY/PROCEDURE/RESPONSIBILITIES:

3.1 Information Security and Privacy Policies

3.1.1 Providers shall develop comprehensive information security and privacy policies and procedures to ensure data security and the protection and confidentiality of client records. The policies and procedures shall address Health Insurance Portability and Accountability Act (HIPAA) privacy and security requirements and shall be updated as necessary.

3.1.2 The King County Regional Support Network (KCRSN) shall appoint a HIPAA Security Officer who together with the King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) Information System (IS) Security Team are responsible for ensuring that security policies and procedures are adequate and are implemented within the King County Mental Health Plan (KCMHP).

3.1.3 Providers shall appoint a provider Security Officer to be responsible for ensuring that security policies and procedures are adequate and are implemented within the provider agency.

3.2 Access to MHCADSD IS

3.2.1 Authorized users may be given access to any of the MHCADSD applications as listed on the MHCADSD "Application for Access" form (Attachment A, Appendix 17A).

3.2.2 Access to MHCADSD IS is restricted by the following:

A. The person accessing the information must have professional qualifications related to the information he/she is seeking; and

B. The person accessing the information must have a 'need to know' the specific information for the assessment or treatment task that is his/her responsibility:

1. To link designated personnel to the mental health care provider responsible for providing services to a KCMHP client;

2. To provide service history information on a client currently requesting or receiving services from a KCMHP provider;

3. To determine the medically necessary level of service for a client; or

4. To audit and validate submissions, if this task is within the scope of the user's job function.

3.2.3 Access to information may be given in some instances primarily for research and or evaluation activities, as specified in Attachment B, Evaluation and Research Review Committee policy and procedure, and the Information for Researcher link on the MHCADSD website.

3.2.4 MHCADSD IS Initial Application process

Authorized staff may request access to the MHCADSD IS and MHCADSD LAN by completing an "Application for Access" form (Attachment A, Appendix 17A) following these procedures:

A. Applicant reads and signs form and has signature witnessed;

B. Supervisor signs form and mails completed document to MHCADSD;

C. MHCADSD Privacy Officer approves application and forwards to the MHCADSD IS;

D. MHCADSD IS creates a user account with appropriate security permissions;

E. MHCADSD sends approved application to applicant and logs user name; and

F. If the application is approved, authorized staff will be granted an account and held personally responsible for all activity on that account, including civil and criminal liability.

3.2.5 MHCADSD IS Renewals and Cancellations

A. Renewals

1. User accounts must be renewed on an annual basis. In order to avoid overload, renewal is set for a 12-month cycle from the date of approval.

2. Renewal requires submission of a signed "Application for Access" form (Attachment A, Appendix 17A) from the named user.

3. Application is sent to MHCADSD for processing. See 3.2.4, A. 2, 3, 5 and 6. The user account is renewed with appropriate security permissions.

B. Cancellations

1. Any account that does not show connect-activity for a period of more than 90 days will become disabled. The user can contact MHCADSD IS to request reactivation of the account.

2. If at any time MHCADSD has any reason to believe an account is being used by a person other than the authorized user, the account shall be immediately disabled. Where an account has been canceled for cause, a signed "Application for Access" must be submitted for reinstatement.

3. When an authorized user leaves employment, the provider is required to notify MHCADSD IS in writing at least five business days in advance of the date of termination. MHCADSD IS will cancel the user's accounts in all information systems, effective the date of termination.

3.2.6 Passwords for MHCADSD IS

Passwords are mandatory for accessing data located on the MHCADSD LAN or the MHCADSD IS server.

A. Passwords shall never be disclosed to others and shall be changed at least every 90 days. Passwords are set to expire at 90 days if not changed. Once the password has expired, the user will not be able to log into the MHCADSD system and must contact MHCADSD IS to request reactivation of the account.

B. Providers shall configure software so that the entry of passwords on the input screen shall be invisible or encrypted, and password files shall be encrypted where possible.

C. Employees shall be held accountable for access to LAN applications gained through the use of their user ID and password combination.

3.3 Data Extracts

3.3.1 Provider staff may request data extracts containing confidential data by following these procedures:

A. Submit an Evaluation and research Proposal Application and all required materials specified in Attachment B, Evaluation and Research Committee and the Information for Researchers link on the MHCADSD website.

B. Prior to submitting a proposal, the requester must have a consultation with an Evaluation and Research Committee member. If identified or identifiable data is being requested from MHCADSD, the requester must also have a consultation with the MHCADSD Privacy Officer prior to proposal submission.

C. The project requiring the use of the data extract must be approved by the Evaluation and Research Committee.

3.4 Release of Client Information from MHCADSD IS

3.4.1 Confidential client information cannot be released without the signed consent or authorization of the client or legally responsible other person except under conditions allowed by state or federal law. Consent or authorization must meet the criteria described in Attachment A, Appendix 8.

3.4.2 Authorized users who receive requests for confidential information shall ensure that all criteria for release of information stated in this manual are met before releasing any information.

Using established data security protocols:

A. Determine the identity and role of the inquirer;

B. Determine if linkage to a service provider is appropriate;

C. Determine if the inquirer has a right to know the information and/or if confidential information must be released in order to provide appropriate services to the client in question;

D. Link the inquirer to a service provider, if appropriate;

E. Disclose to the inquirer only that information deemed necessary to provide service to the client; and/or

F. Refer inquirer to an appropriate agency for assistance if all release-of-information criteria are not met and explain why the request for information is denied.

3.4.3 Providers shall provide assistance to law enforcement and corrections personnel in the most expedient manner possible, but only as allowed by Revised Code of Washington (RCW) 71.05.390(7) and 71.05.63(1) or any successors.

3.4.4 Request for release of information to state corrections personnel are found in Washington Administrative Code (WAC) 388-865-0600 to 0640 or any successors.

3.4.5 Disclosure of confidential information must be recorded according to procedures described in Attachment A, Appendix 10.

3.5 Medical Records

3.5.1 Confidential medical records may be required and requested by the MHCADSD in the course of reviews conducted for outpatient benefit authorization, inpatient certification and authorization for requests for extension, and clinical and administrative site reviews for inpatient and outpatient treatment.

3.5.2 A signed consent or authorization by the client is not required for the disclosure of information to the KCMHP when disclosure purposes directly relate to state plan administrative responsibilities contracted to the KCMHP.

3.5.3 Compliance with any more specific requirements will also be ensured, e.g., substance use disorder treatment, as specified in 42 Code of Federal Regulations (CFR) Section 2 or its successor.

3.5.4 The MHCADSD will request records from a provider as follows:

A. MHCADSD will telephone the client's mental health care provider who will be expected to facilitate the request through the provider's medical records department.

B. MHCADSD will be responsible for verbally defining the purpose of the request and limiting the chart information needed so as to minimize copying work and expense.

C. Records shall be forwarded to MHCADSD within five working days. As per Chapter 70.02 RCW or its successor, a reasonable fee may be charged for these records.

D. When the chart information requested is considerable (as mutually determined), attempts will be made to arrange a site visit by MHCADSD. Such a visit will include the on-site clinical team for clinical consultation and/or disposition planning.

3.5.5 When requesting records from a non-MHP provider, Attachment A, Appendix 3 of this section will be used to inform and document client consent or authorization.

3.5.6 Medical records obtained by MHCADSD will be maintained in a clinical file under the client's name. These files will be kept in a locked cabinet at the MHCADSD office.

3.5.7 Records obtained by MHCADSD for the purpose of clinical review will not be available for review by Ombuds services or the Quality Review Team.

3.6 Electronic Message Systems

3.6.1 PHI may be sent in the body of an e-mail or in an attachment if encrypted:

3.6.2 No PHI may be included in Instant Messaging.

3.7 Internet Access

Providers shall not use the MHCADSD IS to access the Internet except to access web-based applications enabled through the KC Intranet Home Page.

3.8 Computer Viruses

Providers shall develop procedures for protecting client records and MHCADSD data from alteration or destruction by computer virus infections.

3.9 Data Sharing Agreements

KCMHP may at times enter into data sharing agreements with other agencies. All authorized users of the MHCADSD IS are bound by these data-sharing agreements and may not, in any way, deviate from stipulations. Data sharing agreements help protect the MHCADSD IS from potential criminal and civil liability should the data be compromised by another agency. Any user who violates these agreements may be subject to criminal and civil liability.

3.9.1 MHCADSD negotiates data sharing agreements with other entities to:

A. Specifically state, in writing the requirements associated with the sharing of data; and/or

B. Record which external agencies are accessing MHCADSD.

3.9.2 A list of existing data-sharing agreements is available upon request from MHCADSD Fiscal staff.

4.0 LIST OF ATTACHMENTS:

4.1 Attachment A: Protection of Confidential Client Information

4.1.1 Appendix 01: Designated Record Set

4.1.2 Appendix 02: Limited Data Set

4.1.3 Appendix 03: Consent/Authorization to Release Information

4.1.4 Appendix 04: Maximum Potential Access to and Use of PHI by MHCADSD Staff without Client Authorization or Consent

4.1.5 Appendix 05: Routine Disclosure of PHI by MHCADSD Staff

4.1.6 Appendix 06: Crisis Clinic Telephone Requests for Enrollment Information

4.1.7 Appendix 07: Request for Client Information without Authorization

4.1.8 Appendix 08: Form for Invalid Authorizations

4.1.9 Appendix 09: Request to Communicate by Alternate Means

4.1.10 Appendix 10: Log of Disclosures without Client Consent or Authorization

4.1.11 Appendix 11: Request to Revoke Consents/Authorizations for the Release of Information

4.1.12 Appendix 12: Request to Amend or Correct PHI

4.1.13 Appendix 13: Request to Restrict PHI

4.1.14 Appendix 14: Request for Accounting of Disclosures

4.1.15 Appendix 15: Oath of Confidentiality

4.1.16 Appendix 16: Disclosure of Minimum Electronic MH PHI

4.1.17 Appendix 17A: Application for Access to Information System (Providers)

4.1.18 Appendix 17B: Application for Access to Information System (MHCADSD)

4.1.19 Appendix 18: MHCADSD Procedure for Making a CD Containing PHI

4.1.20 Appendix 19: DSHS Oath of Confidentiality

4.1.21 Appendix 20: Business Associate Agreement

4.1.22 Appendix 21: Data Sharing Agreement

4.1.23 Appendix 21-A: Data Security Requirements

4.1.24 Appendix 21-B: Data Disposition Certification

4.1.25 Appendix 21-C: Research and Evaluation Oath of Confidentiality

4.1.26 Appendix 22: Data Sharing Agreement for Limited Data Set

4.1.27 Appendix 23: DSHS PRISM Registration Form

4.2 Attachment B: Evaluation and Research Review Committee

5.0 REFERENCES:

Washington State Law, Regulations, and Policy including any successor, amended, or replacement laws, regulations**,** or policies

- Chapters 388-865, 388-877, 388-877A WAC – Department of Social and Health Services – Mental Health – Community Mental Health and Involuntary Treatment Programs
- Chapter 10.77 RCW – Criminal Procedure – Criminally Insane
- Chapter 13.50 RCW – Juvenile Courts and Juvenile Offenders – Keeping and Release of Records by Juvenile Justice or Care

- Chapter 70.02 RCW – Public Health and Safety – Medical Records – Health Care Information Access and Disclosure
- Chapter 71.05 RCW – Mental Illness – Mental Illness
- Chapter 71.24 RCW – Mental Illness – Community Mental Health Services Act
- Chapter 71.34 RCW – Mental Illness – Mental Health Services for Minors

Other

- The Department of Social and Health Services (DSHS) State Mental Health Contract and any subsequent amendments
- The Department of Social and Health Services (DSHS) PIHP Contract and any subsequent amendments
- Access to Confidential Client Information, MHCADSD Policies and Procedures
- Research, MHCADSD Policies and Procedures

Washington State Laws and Regulations including any successor, amended, or replacement laws, regulations**,** or policies.

- Chapters 388-865, 388-877, 388-877A WAC
- Chapters 10.77, 13.50, 70.02, 71.05, 71.24, 71.34, and 42.17 RCW

Federal Regulations including any successor, amended, or replacement laws, regulations**,** or policies

- CFR Title 45 Standards for Privacy of Individually Identifiable Health Information, Part 164 Security and Privacy

I. PROTECTION OF CONFIDENTIAL CLIENT INFORMATION

1.0 POLICY TITLE: Confidentiality and Security

1.1 Originally Implemented: April 20, 2005

1.2 Reviewed and revised: November 2014

1.3 Officially Adopted: January 2, 2015

1.4 Effective Date: February 2, 2015

1.5 Signed:
Jim Vollendroff, Division Director

2.0 PURPOSE: To define the principles, expectations and requirements regarding the access, use, and disclosure of individual client information by and to King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) staff, contracted service providers, and other individuals or organizations. The policy covers all forms of information access and communication including verbal, written, and electronic. This policy does not cover MHCADSD personnel or payroll records.

3.0 RESPONSIBILITIES:

3.1 MHCADSD is a health care component of King County, a hybrid entity under the Health Insurance Portability and Accountability Act (HIPAA). Within MHCADSD, Chemical Dependency Involuntary Treatment Services, and Crisis and Commitment Services function as health care providers. Some parts of MHCADSD, such as the Mental Health Plan, function as a health care plan. Some parts of MHCADSD are neither provider nor plan. MHCADSD is responsible for ensuring that the use and disclosure of protected health information within and by MHCADSD adheres to all federal and state regulations.

3.2 MHCADSD is exempt from the King County Privacy Policy.

3.3 The MHCADSD HIPAA Privacy Officer has the lead responsibility within MHCADSD for the development and implementation of this policy.

3.3.1 The Privacy Officer may designate persons to assist in this function. At a minimum, designees shall be sited at Crisis and Commitment Services.

3.3.2 The Privacy Officer shall document the names of all designees and update as needed. The documentation shall be retained for six years beyond the date when each Privacy Officer concludes his/her responsibilities.

3.3.3 All privacy policies and procedures created to meet the requirements of 45 Code of Federal Regulations (CFR) 164 Subpart D Notification in the Case of Breach of Unsecured Protected Health Information and Subpart E Privacy of Individually Identifiable Health Information shall be documented prior to implementation.

3.3.4 Documentation of all privacy policies and notices shall be retained by the Privacy Officer for six years beyond the date when it was last in effect.

3.3.5 Documentation of breaches of unsecured protected health information, risk assessments, and all efforts to address them shall be retained by the Privacy Officer six years from the date of the event.

3.4 The MHCADSD HIPAA Complaint Officer has the lead responsibility within MHCADSD for the review of complaints from MHCADSD staff, clients, and others and the provision of further information about matters covered by the Notices of Privacy Practices.

3.4.1 The Complaint Officer may designate persons to assist in these functions. At a minimum, designees shall be sited at Crisis and Commitment Services.

3.4.2 The Complaint Officer shall document the names of all designees and update as needed. The documentation shall be retained for six years beyond the date when each Complaint Officer concludes his/her responsibilities.

3.4.3 Communications regarding complaints, when required to be in writing, will be retained by the Complaint Officer for six years beyond the date when it was created.

3.5 The MHCADSD HIPAA Security Officer has the lead responsibility within MHCADSD for the development and implementation of the policies and procedures required by 45 CFR 164 Subpart C Security Standards for the Protection of Electronic Protected Health Information.

3.5.1 The Security Officer may designate persons to assist in these functions.

3.5.2 The Security Officer shall document the names of all designees and update as needed. The documentation shall be retained for six years beyond the date when each Security Officer concludes his/her responsibilities.

3.5.3 All security policies and procedures created to meet the requirements of HIPAA will be documented prior to implementation.

3.5.4 Documentation of all security policies shall be retained by the Security Officer for six years beyond the date when each was last in effect.

3.5.5 Documentation of all security breaches or other incidents and efforts to address them shall be retained for six years from the date of the event.

3.6 MHCADSD individual staff shall receive training appropriate to their job functions regarding privacy and security policies and procedures. All staff are responsible for complying with these policies and procedures. When a staff person encounters a situation not covered by these policies and procedures, he/she shall consult with the Privacy Officer before taking action.

3.7 MHCADSD contracted providers are responsible for their own compliance with privacy and security laws and regulations.

4.0 CONFIDENTIALITY POLICY AND PROCEDURES:

4.1 Goals

4.1.1 To protect the privacy, security, integrity, and availability of all protected health information created, received, maintained, or transmitted by MHCADSD.

4.1.2 To ensure that all access, use, disclosure, and requests of individual client information meet all state and federal requirements.

4.1.3 To protect against any reasonably anticipated threats or hazards to the security or integrity of such information.

4.2 Categories of client information

4.2.1 Protected health information (PHI)

A. For the purposes of this policy, protected health information is information that:

1. Is created or received by a health care provider or health plan;

2. Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual;

3. Identifies that individual or, with respect to which there is reasonable basis to believe the information can be used to identify the individual; and

4. Is transmitted or maintained in any form or medium by a provider or health plan.

B. ePHI is that subset of PHI that is transmitted or maintained electronically.

C. Photographs and other images of a client are considered PHI and are therefore subject to all the protections of PHI.

D. PHI does not include:

1. Education records covered by the Family Educational Right and Privacy Act; or

2. Employment records held by MHCADSD in its role as an employer.

4.2.2 Designated record set

A. A designated record set is a group of records maintained by MHCADSD which includes PHI and is used for the purpose of enrollment, assessment, treatment, billing, care management, or any other decisions about an individual.

B. See Section XIII: Attachment A, Appendix 1 Designated Record Set.

4.2.3 De-identified information

A. De-identified individual client information is information wherein the individual is not identified and there is a reasonable basis to believe the information cannot be used to identify the individual. As de-identified information is considered not to be individually identifiable health information, it is no longer protected health information.

B. De-identified individual client information may be used or disclosed without the protections required for identifiable individual client information, as long as any means of re-identifying the information, if such means exists, is kept confidential.

C. To determine that protected health information is not identifiable, MHCADSD shall:

1. Have someone knowledgeable in statistics and scientific principles determine that it is so and document methods and analyses used for the opinion; or

2. Remove from the information the identifiers of the individual, relatives, employers, or household members described in 45 CFR 164.514(b).

D. King County Identification (KCID) and authorization numbers shall always be removed for information to be considered de-identified.

E. MHCADSD may assign a code or other means to re-identify de-identified information if the code or other means is not used or disclosed for any other purpose.

4.2.4 Limited data set

A. A limited data set is protected health information that excludes the specific identifiers of an individual or his/her relatives, employers, or household members as listed in XIII: Attachment A, Appendix 2 Limited Data Set and in 45 CFR 164.514(e).

B. A limited data set may be used or disclosed only for the purpose of research, public health, or health care operations.

4.2.5 Data Sharing Agreements

A. MHCADSD may disclose a dataset that is either limited or containing PHI only after an appropriate data sharing agreement has been executed (Appendix 21 Data Sharing Agreement and Appendix 22, Data Sharing Agreement for Limited Data Set). The data sharing agreement shall:

1. Establish the purpose for which the data will be used;

2. Confirm that the purpose is research, public health, or health care operations;

3. Stipulate that the data may not be used for any purpose not designated in the agreement;

4. Establish who is permitted to use or receive this data;

5. Establish the safeguards the recipient will have in place to ensure the data is used or disclosed only as agreed;

6. Require that the recipient report to MHCADSD any use or disclosure not permitted by the agreement; and

7. Require that the recipient shall not attempt to identify the clients described by the data set or attempt to contact these individuals.

B. Data sharing agreements shall be approved by the Privacy Officer as well as MHCADSD management.

C. Copies of data sharing agreements shall be kept by the Privacy Officer or designee and also centrally filed for general reference.

4.2.6 Should MHCADSD become aware of a violation of a data sharing agreement, the Privacy Officer shall take reasonable steps to end the violation. If such steps are unsuccessful, the Officer may:

A. Restrict any further disclosure of data to the recipient; or

B. Report the problem to the Secretary of Health and Human Services.

4.3 Consent

4.3.1 A consent is a client's permission for MHCADSD to disclose protected health information for purposes of treatment, payment, and/or healthcare operations.

4.3.2 Written client consent shall be obtained whenever required by state law or 42 CFR Part 2.

4.3.3 A parent, guardian, or personal representative may consent to the use or disclosure of the client's information when allowed by law. A guardian or personal representative and, in some cases, a parent shall be asked to provide documentation of the relationship to the client.

4.3.4 To be valid, a consent must be:

A. Written;

B. Signed and dated by the client (or, if allowed or required, the parent, guardian, or other legal personal representative);

C. Identify the information to be disclosed in a specific and meaningful fashion;

D. Identify the purpose of the disclosure;

E. Identify the name, address and affiliation of the person to whom the information is to be disclosed;

F. Identify the organization who is making the disclosure;

G. Include an expiration date or an expiration event that relates to the client or the purpose of the use or disclosure. Disclosures regarding persons under the supervision of the Department of Corrections shall expire at the end of the term of supervision, unless the client is part of a treatment program that requires the continued exchange of information until the end of the period of treatment; and

H. Include a statement on revocability.

4.3.5 Consents for children

A. For children under 13, a parent or guardian must sign all consents for release of information.

B. For children age 13 and over, the person who must consent is determined by the type of treatment described in the records.

1. Inpatient substance use disorder (SUD) treatment records may be released only with the consent of the child and a parent (or guardian).

2. Inpatient mental health (MH) treatment records may be released only with the consent of the child.

3. Outpatient SUD or MH treatment records may be released only with the consent of the child.

4.3.6 To obtain consent, MHCADSD staff may use a form in Section XIII: Attachment A, Appendix 3 Consent/Authorization to Release Information. These forms must be reapproved by the HIPAA Privacy Officer annually.

4.3.7 MHCADSD staff may revise a form in Attachment A for repetitive use in particular circumstances. Any such forms used shall be approved by the HIPAA Privacy Officer annually.

4.4 Authorization

4.4.1 An authorization is a client's permission for MHCADSD to use or disclose protected health information.

A. Written client authorization for the use or disclosure of the individual's health information shall be obtained whenever required by law.

B. An authorization is not required when the purpose of the use or disclosure is treatment, payment, or health care operations.

C. There are some situations in which an authorization is not required, as indicated below under Disclosures.

4.4.2 A parent, guardian, or personal representative may authorize the use or disclosure of the client's information when allowed by law. A guardian or personal representative and, in some cases, a parent shall be asked to provide documentation of the relationship to the client.

4.4.3 A client may not be refused enrollment or treatment if he/she refuses to sign an authorization.

4.4.4 To be valid, an authorization must be:

A. Written;

B. Signed and dated by the client (or, if allowed or required, the parent, guardian, or other legal personal representative);

C. Identify the information to be disclosed in a specific and meaningful fashion;

D. Identify the purpose of the use or disclosure. When the authorization is initiated by a client, the client may state "at the request of the individual" rather than describe his/her purpose;

E. Identify the name, address, and affiliation of the person who will use the information or to whom the information is to be disclosed;

F. Identify the organization who is using or disclosing the information;

G. Include an expiration date or an expiration event that relates to the client or the purpose of the use or disclosure, except:

1. Disclosures regarding persons under the supervision of the Department of Corrections shall expire at the end of the term of supervision, unless the client is part of a treatment program that requires the continued exchange of information until the end of the period of treatment; or

2. The authorization shall expire 90 days after the signing when an authorization permits the disclosure of health care information to a financial institution or an employer of the client for purposes other than payment, unless renewed by the client;

H. Include a statement on revocability:

1. Include how to revoke and exceptions to right to revoke; or

2. Refer the client to an MHCADSD Notice of Privacy Practices for more information on revocation;

I. Include a statement that information used or disclosed may be subject to redisclosure by the recipient and no longer be protected;

J. Include a statement that the division will not condition treatment, payment, enrollment, or eligibility for benefits on the individual's providing authorization; and

K. Include a statement that the client is entitled to a copy of the signed authorization.

4.4.5 Authorization for children

A. For children under 13, a parent or guardian must sign all authorizations for release of information.

B. For children age 13 and over, the person who must authorize is determined by the type of treatment described in the records.

1. Inpatient SUD treatment records may be released only with the authorization of the child and a parent (or guardian).

2. Inpatient MH treatment records may be released only with the authorization of the child.

3. Outpatient SUD or MH treatment records may be released only with the authorization of the child.

C. MHCADSD may withhold information from a parent or guardian if there is a known history of abuse or neglect of the child by this parent or guardian or there is other reason to believe that giving access to the child's information will endanger the child.

4.4.6 To obtain authorization, MHCADSD staff may use a form in Section XIII: Attachment A, Appendix 3 Consent/Authorization to Release Information. These forms must be reapproved by the HIPAA Privacy Officer annually.

4.4.7 MHCADSD staff may revise a form in Attachment A for repetitive use in particular circumstances. Any such forms used shall be approved by the HIPAA Privacy Officer annually.

4.5 Minimum necessary

4.5.1 When accessing, using, disclosing, or requesting client protected health information without client authorization, the information accessed, used, disclosed, or requested shall be limited to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request, except in those circumstances where a deviation from this restriction is legally allowed.

4.5.2 The minimum necessary restriction is not required by law when:

A. The disclosure is directly to the client or to the personal representative of the client;

B. The disclosure has been authorized by the client;

C. The disclosure is to a health care provider for the purpose of providing treatment to the client;

D. The request is for the purpose of MHCADSD CCS staff providing treatment to the client;

E. The use or disclosure is required by law and such use or disclosure is limited to the relevant requirements of such law;

F. The use or disclosure is required to comply with HIPAA; or

G. The disclosure is to the Secretary of Health and Human Services who is investigating a privacy complaint or conducting an audit of our compliance with privacy requirements.

4.5.3 For access and use without a client's consent or authorization by MHCADSD staff:

A. MHCADSD shall reasonably safeguard access to protected health information by those staff who are not defined as needing such information for their job functions;

B. For the access and use of protected health information without client consent or authorization, MHCADSD staff are restricted as follows:

1. Access and use is based on staff's "need to know" related to his/her role and assigned responsibilities within the division. Access and use may be defined as individual PHI and/or reports developed from individual PHI;

2. Access and use by operations unit clinical staff is restricted in that the person seeking the information shall have professional qualifications related to the information he/she is seeking;

a. For access to MH information, the operations unit staff shall be a mental health professional, registered counselor, or the equivalent;

b. For access to SUD information, the operations unit staff shall be a certified chemical dependency professional or the equivalent;

3. Access and use of electronic protected health information requires the approval by the staff's supervisor and the Privacy Officer;

4. Allowed access and use does not imply the authority to share information with other staff in the division who do not have the approved access;

5. A supervisor may access and use any information that is accessed or used by staff he/she supervises;

6. When staff requires information for routine but infrequent use, time-limited access shall be granted;

7. When staff requires information in order to temporarily assume the responsibilities of another staff, time-limited access shall be granted;

8. MHCADSD staff performing MH clinical functions may access only mental health information. Similarly, MHCADSD staff performing SUD clinical functions may access only substance use disorder information; and

9. Access and use is restricted according to Section XIII: Attachment A, Appendix 4 Maximum Potential Access to and Use of PHI by MHCADSD Staff without Client Authorization or Consent.

C. Procedure for access and use

1. All MHCADSD staff job descriptions shall include a description of the protected health information the staff may need to access for assigned tasks, if more restricted than that described in Section XIII: Attachment A, Appendix 4.

2. Access by MHCADSD staff to electronic protected health information requires a completed application to the Privacy Officer. See Attachment A, Appendix 17B Application for Access to Information Systems MHCADSD Staff.

3. Staff who must compile and share PHI as part of his/her job functions shall do so in accordance with established internal MHCADSD procedures a restricted file maintained on a secure drive.

4. Staff who compiles PHI as part of his/her job functions and need not share it with others may store it on his/her home drive on the network. However, PHI may not be placed on a work station's C drive or on any equipment or media personally owned by an MHCADSD staff person.

5. Preferred means for the communication of PHI are phone call, confidential voicemail, encrypted email, secure fax, or mailed/couriered paper, disc, or compact disc.

6. PHI transmitted by e-mail must use encryption methods approved by the MHCADSD IS Security officer. Password protection of an attachment may not be substituted for encryption.

    a. Exceptions to encryption may be allowed when:

        i. Encryption is not available; and

        ii. The only PHI are KCID, Authorization number, Docket number (in the case of involuntary commitment court records), and Agency ID numbers; and

        iii. The email does not include information about more than ten individuals.

    b. Additional requirements for PHI in emails:

        i. When receiving an email and any attached documents, these must be immediately removed from the inbox to a personal folder; or "fully" deleted; and

        ii. When sending an e-mail, the subject line must include the words "Confidential PHI" to ensure ease of redaction should there be a public disclosure request. The sent email and any attached documents must be immediately removed from the sent items folder to a personal folder, or "fully" deleted.

7. Encrypted email is not an alternative to using the secure access folders for transmitting/ receiving "large" files containing individually identifiable information and/or PHI.

8. No PHI may be included in Instant Messaging or in Net Meeting transmissions.

4.5.4 For access and use of protected health information without a client's authorization or consent by King County staff outside of MHCADSD

A. The director and staff of the Department of Community and Human Services, who are outside MHCADSD, may access or use the minimum necessary protected health information for the purpose of health care operations. Such requests shall first be approved by the Privacy Officer in consultation with the MHCADSD director or assistant director(s).

B. Staff of other county departments or offices may not access or use protected health information without a business associate agreement or memorandum of understanding.

C. Persons on the Alcohol and Substance Abuse Board or the Mental Health Advisory Board may not access or use identified protected health information.

4.5.5 For disclosure by MHCADSD staff without a client's authorization, the Privacy Officer shall ensure that the minimum necessary restriction is applied whenever required by law.

A. The minimum necessary restriction for routine releases

1. The Privacy Officer shall review for approval each routine and recurring disclosure of protected health information to ensure it meets the minimum necessary restriction, when that restriction applies.

2. Once a routine release is approved by the Privacy Officer, the disclosure may recur as needed without additional approval unless the disclosure changes as to recipient, purpose, content, or any other aspect of the disclosure.

3. See Section XIII: Attachment A, Appendix 5 Routine Disclosures of PHI by MHCADSD Staff without Client Consent or Authorization for a list of routine disclosures. Disclosures for treatment, payment or healthcare operations do not need to be tracked for the purpose of an accounting.

B. The minimum necessary restriction for non-routine releases

1. The Privacy Officer shall review each non-routine request for disclosure of protected health information to ensure it meets the minimum necessary restriction.

2. When the request for information comes from the following persons or entities, the specifically requested information may be assumed, at the discretion of the Privacy Officer, to be the minimum necessary:

a. Public officials who may receive protected health information without client authorization, when the official represents that the information requested is the minimum necessary for the stated purpose;

b. Another covered entity;

c. A staff person of a business associate of another covered entity who is providing professional services to the covered entity, when the person represents that the information requested is the minimum necessary for the stated purpose; or

d. A researcher whose research has been approved by the MHCADSD Evaluation and Research Committee.

3. For all other non-routine releases, the following guidelines apply:

   a. A whole medical record shall not be used or disclosed unless the entire record is specifically justified as the amount that is reasonably necessary for the stated purpose;

   b. A limited data set may be considered the minimum necessary information for disclosure when there is a limited data set sharing agreement (Appendix 22, Data Sharing Agreement for Limited Data Set) and the data are for research, public health, or health care operations;

   c. All elements in an electronic transaction under 45 CFR Part 162 are considered necessary when one element in an electronic transaction is required; and

   d. All contractually required disclosure of individual client information is considered the "minimum necessary."

4. Some non-routine releases will need to be covered by a data-sharing agreement.

4.5.6 When MHCADSD staff request PHI of another provider, plan, or any other source without a client's authorization, the individual staff shall ensure that the minimum necessary restriction is applied whenever required by law.

Guidelines for the determination of minimum necessary for the request for protected health information are as follows:

A. A whole medical record shall not be requested unless the entire record is specifically justified as the amount that is reasonably necessary for the stated purpose. A whole medical record may be requested for use during an on-site audit;

B. A limited data set may be considered the minimum necessary information for request when there is a data use agreement and the data are for research, public health, or health care operations;

C. All elements in an electronic transaction under 45 CFR Part 162 are considered necessary when one element in an electronic transaction is required; and

D. All contractually required requests of protected health information are considered the "minimum necessary."

4.6 Disclosures

4.6.1 All disclosures of PHI by MHCADSD staff to persons, who are not approved for its access and use, as described above, shall occur according to state and federal law.

4.6.2 Authorization is not required for the disclosure of protected health information:

A. To the individual;

B. To the legal personal representative of the individual;

C. To the parent, guardian, or other person acting in loco parentis, as allowed by law;

D. To a health care provider or entity for the purpose of treatment, payment, or health care operations:

1. For the purpose of treatment, the fact of enrollment in the Mental Health Plan, the identity of the treatment agency, and the identity of the case manager may be released without authorization or consent to the health care providers or entities. Additional information may be released in certain situations. See Section XIII, Attachment A, Appendix 6 Redisclosure of Enrollment Information without Client Consent; and

2. Other disclosures for the purpose of treatment may require a consent;

E. To a public health authority for the purpose of preventing or controlling disease, injury, or disability;

F. To a public authority authorized by law to receive reports of child or vulnerable adult abuse or neglect:

1. To the extent the disclosure is required by law and the disclosure complies with and is limited to the relevant requirement of such law;

2. To the extent that the disclosure is authorized by law and MHCADSD feels the disclosure is necessary to prevent serious harm to the individual or other potential victims;

3. When such a disclosure is made, no information(e.g., the identity of the caller) may be given that indicates the client is known to have a past or present substance use disorder, should this be the case for elder abuse or neglect; or

4. When a disclosure has been made, the MHCADSD staff person making the disclosure must inform the client (or parent, guardian, or personal representative) unless it is determined by a MHCADSD licensed professional that:

a. Informing the client would place him/her at risk of serious harm; or

b. Informing the parent, guardian, or personal representative would place the client at further risk;

G. To the Food and Drug Administration (FDA) for the purpose of activities related to the quality, safety, or effectiveness of such FDA-regulated product or activity;

H. To a health oversight agency, as authorized by law;

I. To a health oversight agency and another entity investigating a claim of public benefits not related to health;

J. To an individual or organization in response to a lawful court order (court orders and subpoenas should be referred to legal review);

K. To law enforcement, and only when allowed or required by law,[1] this includes:

1. Reports of child or vulnerable adult abuse, as noted above;

2. Disclosures in response to a lawful court order, as noted above;

3. Disclosures made in the event of a crisis or emergent situation, for the purpose of averting a serious threat to public health or safety; or

4. Reporting a crime on MHCADSD premises;

L. To the target of a threat, when the person is reasonably able to prevent or lessen the threat;

M. To correctional institutions as necessary for treatment or for the protection of the health and safety of others, only if the client is an inmate residing in an institution;

N. To the state Department of Corrections:

1. For the purposes of completing presentence investigations or risk assessment reports, supervision of an incarcerated offender or offender under supervision in the community, planning for and provision of supervision of an offender, or assessment of an offender's risk to the community; and

2. For the purpose of containing an emergency or locating an offender, in which case information related to mental health services delivered to the offender and, if known, information regarding where the offender is likely to be found. Information released in response to an oral request is limited to known whereabouts of the offender and the fact of current receipt of services;

O. To the federal government for specialized government functions;

P. To researchers for research activities approved by the MHCADSD Evaluation and Research Committee;

[1] 42 CFR 2.12(5), 45 CFR 164.502(j)(2), 45 CFR 164.512(f), RCW 71.05.390(7),(10(a)) & (11)

Q. To a coroner, medical examiner, or funeral director; or

R. Incidental to a use or disclosure that is legally allowed.

4.6.3 In addition to the above, disclosures without authorization may be made in a disaster, if the following conditions are met:

A. If the client is present, he/she is given an opportunity to object, or

B. If the client is not present or is incapacitated, MHCADSD staff determine that the disclosure is in the best interests of the client or the disclosure is necessary to allow an authorized disaster relief entity to perform its function.

4.6.4 Disclosures made with or without authorization are not considered a violation if the disclosure is made by a whistleblower who:

A. Believes in good faith that MHCADSD has engaged in conduct that is unlawful or otherwise violates professional or clinical standards, or that the care, services, or conditions provided by MHCADSD potentially endangers one or more clients, staff persons, or the public, and

B. The disclosure is made to a health oversight agency or public health authority authorized by law to oversee MHCADSD or to the whistleblower's own attorney.

4.6.5 Disclosures to the following are required, whether or not an authorization is obtained:

A. To the person;

B. To the person's parent, guardian, or legal personal representative (when only that person may consent to the client's care);

C. To the Secretary of Health and Human Services; or

D. To a person or organization, pursuant to a lawful court order.

4.6.6 Routine disclosures permitted by law shall only follow the approval of the Privacy Officer. See Section XIII, Attachment A, Appendix 5 for approved routine disclosures.

4.6.7 Non-routine disclosures permitted by law shall be made on case-by-case basis, based on a decision made in consultation with the Privacy Officer. See Section XIII, Attachment A, Appendix 7 Request for Client Information without Authorization.

4.6.8 Procedure for disclosures of PHI

A. Prior to the disclosure of any PHI, the MHCADSD staff who is being asked to disclose information shall ask the Privacy Officer to determine the following:

1. That the disclosure meets all requirements for consent or authorization:

    a. If a consent or authorization is required, the Privacy Officer shall further determine that the document is valid (Section XIII, Attachment A, Appendix 8 Form for Invalid Authorizations); and

    b. If a person requesting information claims that consent or authorization is not required, he/she must cite the legal authority by which he/she can receive PHI without client permission;

2. That the requester's identity is confirmed. Guidelines for verification are:

    a. Client hand-delivers the authorization and presents a picture identification card confirming his/her identity;

    b. The signature on the consent or authorization can be matched to a client signature on file;

    c. The consent/authorization form or any accompanying cover letter is on recognizable letterhead; or

    d. Notarized signature on the authorization;

3. That no business associate or data sharing agreement is required; and

4. That minimum necessary standards are met.

B. When the above requirements for disclosure are met, the PHI is prepared for disclosure.

C. The MHCADSD staff person shall then disclose the information. For disclosures to a client, the client may request receiving confidential communications by alternative means or at alternative locations, if he/she clearly states that the disclosure could endanger himself/herself. See Section XIII, Attachment A, Appendix 9 Request to Communicate by Alternate Means or at an Alternate Location.

D. If the disclosure is made on the basis of an MHCADSD authorization (Section XIII, Attachment A, Appendix 3), signed by the client, the client is given a copy of the authorization.

E. Documentation of a disclosure shall occur in all instances whereby the disclosure would need to be reported in a client-requested accounting. See Section XIII, Attachment A, Appendix 10 Log of Disclosures without Client Consent or Authorization.

F. Documentation of a disclosure shall occur for all disclosures by Crisis and Commitment Services (CCS) and Chemical Dependency Involuntary Treatment Services (CDITS) except disclosures to third-party payors.[2]

G. Documentation of disclosures not required in an accounting and not required by staff of CCS, or CDITS may occur.

H. Any documentation of a disclosure shall include the following:

1. For non-routine disclosures of PHI of an individual client, the MHCADSD staff making the disclosure shall document:

a. The date of the disclosure;

b. The staff making the disclosure;

c. The recipient of the PHI;

d. The means of disclosure (e.g., phone, mail, e-mail, fax);

e. A description of the information disclosed;

f. The purpose of the disclosure; and

g. The authority allowing the disclosure;

2. For those disclosures required to be logged on Section XIII, Attachment A, Appendix 10, the log suffices for the documentation of that disclosure; and

3. For routine disclosures with consent or authorization:

a. Review the consent or authorization with the Privacy Officer or site designee to determine that all of the required fields are present; and

b. For Offender Re-entry Community Safety Program (ORCSP) consents, compare with the required elements and determine that all of the blanks have been completed. Take any questions to the Privacy Officer.

I. For clients with a paper record kept at MHCADSD, the documentation of a disclosure shall be kept in this record. For clients without a paper record, the documentation shall be kept in a combined file.

J. When the Privacy Officer approves only part of a request for disclosure, only the information approved shall be disclosed. When this occurs, the Privacy Officer shall place in the client record an explanation for the partial approval.

[2] RCW 70.02.020

K. When an authorization for disclosure is denied, the authorization is returned to the requester with an explanation for the denial. A copy of the authorization and the denial letter is filed in the client file.

4.6.9 MHCADSD staff who do not use or access PHI without consent or authorization as defined under the Minimum Necessary section above may access PHI with client consent or authorization.

4.7 Redisclosure of Substance Use Disorder Information

4.7.1 Redisclosure occurs when individual client information, disclosed to an individual or organization with or without authorization, is disclosed to another individual or organization.

4.7.2 Redisclosure of individual client substance use disorder (SUD) information is prohibited by 42 CFR Part 2 except with a proper authorization.

4.7.3 All disclosures shall be stamped: "This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."

4.8 Revocations of consents or authorizations for disclosure

4.8.1 When a request for a consent or authorization revocation is received, the revocation request is forwarded to the Privacy Officer who shall do the following:

A. Verify the identity of the requester by comparing the signature on the revocation request with the original consent or authorization;

B. Write "VOID" in large red letters across the original consent or authorization with the date and initials of the staff; and

C. File the revocation request with the original consent or authorization.

4.8.2 A client may use Section XIII, Attachment A, Appendix 11 Request to Revoke Consent to request a revocation.

4.8.3 When a request for a disclosure of protected health information is received referencing a previously received consent or authorization, the MHCADSD staff receiving the request shall ask the Privacy Officer to determine that the consent or authorization remains valid. Information may be disclosed only if the previously received consent or authorization has not been revoked and has not expired. The procedure is the same as for other disclosures.

4.9 Privacy and Security Committee

4.9.1 The Privacy and Security Committee:

A. Develops and implements privacy and security policies and procedures;

B. Reviews and modifies as needed policies and procedures related to electronic technology as technology changes;

C. Monitors adherence to procedures; and

D. Reviews and approves training curriculum for new staff at point of hire as well as curriculum for ongoing training to current staff.

4.9.2 The committee is chaired by the Privacy Officer. Both the Complaint and Security Officers are committee members. Other MHCADSD staff may be appointed to serve on this committee.

4.10 Business Associates

4.10.1 A business associate relationship exists with an individual or business when that individual or business uses or discloses protected health information in performing a function or activity on behalf of MHCADSD.

4.10.2 A business associate that is internal to the County shall enter into a memorandum of understanding, which clearly states the necessary privacy and security protections for Protected Health Information. The memorandum of understanding must meet the requirements of a business associate agreement.

4.10.3 When the purpose of the business association is other than the provision of treatment, MHCADSD shall require that business associates enter into a business associate contract.

4.10.4 Should MHCADSD staff become aware of a material breach or violation of the business associate's obligation under the contract, MHCADSD shall provide an opportunity for the business associate to cure the breach or end the violation. If the business associate does not cure the breach or end the violation within the time specified by MHCADSD, the business associate contract shall be terminated.

4.10.5 Establishing business associate arrangements

A. All staff shall report to the Privacy Officer any time they are considering the development of a business relationship with another individual or organization that will collect or use PHI to conduct MHCADSD-related work, to determine if a business associate agreement is required.

B. When developing a business associate agreement, staff shall ensure that the contract or agreement:

1. Defines what, if any, PHI will be collected and/or used to conduct MHCADSD-related work;

2. Utilizes the King County Agency Services Contract boilerplate, or the approved Business Associate Agreement template (Appendix 20):

    a. The contract boilerplate or business associate agreement address requirements to:

        i. Use appropriate safeguards and comply, where applicable, with subpart C of the Security Rule, with respect to electronic protected information, to prevent use or disclosure of the information other than as provided for by its contract or business associate agreement;

        ii. Report breaches of unsecured PHI as required by the data-breach-reporting rule;

        iii. Obtain written agreements with subcontractors who create, receive or maintain ePHI to comply with Security Rule; and

        iv. Comply with the Privacy Rule to the extent that the business associate is to carry out a covered entity's obligation under the Privacy Rule (for example, providing individuals with access to health information);

3. Is not modified or changed without the approval of the Privacy Officer and counsel;

4. Is subject to on-site audits; and

5. Allows for the Privacy and Security Officers to review the associate's privacy and security policies and/or other supporting information on request.

4.10.6 Requests that a business associate disclose protected health information

A. Should the business associate collect protected health information that is used in the performance of its work for the division but is not submitted to the division, the business associate is responsible for complying with all privacy and security practices related to PHI disclosure.

B. Should the business associate have submitted all protected health information collected to the division, it may refer disclosure requests to the division.

4.11 Client rights related to protected health information

4.11.1 Notice

A. Each client for whom MHCADSD receives protected health information in our role as plan or provider shall receive a Notice of Privacy Practices which describes:

1. How we access, use, and disclose PHI without client consent or authorization;

2. How we protect client privacy; and

3. Client privacy rights and how to exercise them.

B. For children under age 13 and others legally unable to consent to treatment, the notice shall be given to the client's parent, guardian, or legal personal representative.

C. MHCADSD shall not use or disclose individual client information in a manner inconsistent with the notice.

D. In most cases, a Notice shall be given to each client prior to receiving services.

E. The Notices shall contain all elements defined in 45 CFR Part 164.520 and shall include a statement that we reserve the right to make a change in how MHCADSD handles PHI.

F. Whenever MHCADSD plans to change how it handles PHI such that the Notices shall no longer be accurate, an updated version shall be developed and distributed as required by law prior to the planned change.

G. Only the Privacy Officer may change notices.

H. All notices, including those currently in effect and those in effect in the past, shall be kept on file by the Privacy Officer.

I. Procedures for the distribution of Notices:

1. MHCADSD staff shall distribute the MHCADSD Mental Health Plan Notice of Privacy Practices with the Notices of Determination and/or Notices of Action as specified in Section III, Attachment H. When services are initially authorized; and

2. Annually when authorized to have services continued.

a. When MHCADSD has made a material change to the Notice of Privacy Practice, the change must be prominently posted, or a copy of the revised Notice on the website by the effective date of the change; and

b. Provide a copy of the revised Notice, or information about the change and how to request a copy of the revised Notice, in the next annual mailing.

3. The MHCADSD Mental Health Plan Notice of Privacy Practices shall be distributed by MHCADSD staff to clients authorized for community psychiatric inpatient care.

4. Crisis and Commitment Services shall:

   Distribute the MHCADSD Notice of Privacy Practices to clients at the time of the evaluation. Should a client be assessed on more than one occasion, he/she shall receive a notice at the start of each assessment;

   a. Document the date the notice was received by the client; and

   b. Obtain a written acknowledgment of receipt of the notice by the client or the good faith effort to obtain the acknowledgment including why it was not obtained (e.g., “client refused”).

5. Chemical Dependency Involuntary Treatment Services shall:

   a. Distribute the MHCADSD Chemical Dependency Involuntary Treatment Services Notice of Privacy Practices to clients at the time of the evaluation. Should a client be evaluated on more than one occasion, he/she should receive a notice at the start of each evaluation;

   b. Document the effective date of the notice given the client and the date given; and

   c. Obtain a written acknowledgment of receipt of the notice by the client or the good faith effort to obtain the acknowledgment including why it was not obtained (e.g., “client refused”).

6. No MHCADSD Notice of Privacy Practices shall be distributed by substance use disorder contracted providers.

J. Posting on website

1. A copy of each Notice of Privacy Practices shall be posted on the MHCADSD website.

2. Each subsequent revised version shall be posted with the dates in effect clearly specified.

3. Each version (identified by effective date) shall be posted no later than the date on which it becomes effective.

4.11.2 Requests to copy or inspect under HIPAA

A. A client may request to inspect or copy his/her own designated record set.

B. For copies, the client may be assessed a fee of 15 cents a page.

C. To request to inspect or copy one's own confidential information, a client must make the request in writing.

1. The client may use a fully completed Section XIII, Attachment A, Appendix 3 for this purpose.

2. The client may submit instead a request containing all the elements in Section XIII, Attachment A, Appendix 3.

D. The client shall submit the request to the Privacy Officer or designee, who shall determine if there is any information which shall not be released under the law.

E. Within 15 working days, the Privacy Officer shall respond to the request to copy or inspect either by fulfilling the request or explaining to the client why the request cannot be granted.

F. MHCADSD may deny the request if the information was compiled in reasonable anticipation of or for use in a civil, criminal or administrative action or proceeding. Such a denial may not be appealed.

G. MHCADSD may also deny the request when a licensed mental health professional has determined that:

1. The access requested is reasonably likely to endanger the life or safety of the client or another person;

2. The access requested is likely to cause harm to another person referenced in the records; and

3. The access is requested by the client's personal representative and the access requested is likely to cause harm to the client or another person.

These denials may be appealed.

H. An appeal request shall be made in writing.

I. The appeal is reviewed by a licensed health care professional who did not participate in the original decision to deny.

J. MHCADSD shall comply with the appeal decision.

K. MHCADSD shall act on an appeal request within 30 days. The response shall be in writing unless the client has requested an alternative format.

4.11.3 Requests to amend

A. To request to amend one's own protected health information, a client shall make a request in writing.

1. The client may use a fully completed Section III, Attachment A, Appendix 12 Request to Amend or Correct Protected Health Information for this purpose.

2. The client may submit instead a written request containing all the elements in Section XIII, Attachment A, Appendix 12.

B. The client submits the request to the Privacy Officer or designee, who shall forward the request to an appropriate MHCADSD licensed health care professional.

C. MHCADSD may deny the request when a licensed health professional has determined that:

1. The information is accurate and complete;

2. MHCADSD was not the originator of the information, unless the originator is no longer available to directly act on the request;

3. The information the client amended is not part of the designated record set; or

4. The information was compiled in reasonable anticipation of or for use in a civil, criminal or administrative action or proceeding.

D. MHCADSD shall act on the client's request ten working days after receipt of the request.

E. If the request is approved, MHCADSD shall:

1. Inform the client that the amendment has been approved. The response shall be in writing unless the client has requested an alternative format;

2. Identify the information in the designated record set that is affected by the amendment and either append the information or provide a link to the amendment; and

3. Inform the entities with which MHCADSD has disclosed this information that the information has been amended;

F. If the request is denied, MHCADSD shall provide the client with a written denial that contains:

1. The basis for the denial;

2. The individual's right to submit a written statement disagreeing with the denial and how the individual may file such a statement;

3. A statement that, if the individual does not submit a statement of disagreement, the individual may request that MHCADSD provide the individual's request for amendment and the denial with any future disclosures of the information that is the subject of the amendment; and

4. A description of how the client may complain to MHCADSD or to the Secretary of Health and Human Services, with specific names (or titles) and phone numbers.

4.11.4 Requests to restrict

A. A client may request that MHCADSD restrict the access, use, and disclosure of his/her protected health information. To do so, a client shall make a request in writing as follows:

1. The client may use Section XIII, Attachment A, Appendix 13 Request to Restrict Access, Use or Disclosure of Protected Health Information for this purpose; or

2. The client may instead submit a written request containing all elements in Section XIII, Attachment A, Appendix 13.

B. The client submits the request to the Privacy Officer or designee.

C. The Complaint Officer shall respond to the request within 30 days. The response shall be in writing unless the client has requested an alternative format.

D. MHCADSD is not required to agree to requested restrictions. However, when MHCADSD does agree, the restriction shall be followed.

4.11.5 Requests for an accounting

A. A client may request an accounting of disclosures of his/her PHI made by MHCADSD in the six years prior to the date on which the accounting is requested, except for disclosures:

1. To carry out treatment, payment, and health care operations;

2. To the client;

3. Incidental to a use or disclosure otherwise permitted or required;

4. Pursuant to an authorization;

5. To persons caring for the client in a disaster;

6. For national security or intelligence purposes allowed by law;

7. To correctional institutions or law enforcement officials as allowed by law;

8. As part of a limited data set as defined above; or

9. That occurred prior to April 14, 2003.

B. An accounting shall consist of the following information about each disclosure (Section XIII, Attachment A, Appendix 10):

1. The date of the disclosure;

2. The staff person making the disclosure;

3. The recipient of the PHI;

4. The means of disclosure (e.g., phone, mail, e-mail, fax);

5. A description of the information disclosed;

6. The purpose of the disclosure; and

7. The authority allowing the disclosure.

C. To request an accounting of the disclosures of one's PHI, a client must make a request in writing.

1. The client may use a fully completed Section XIII, Attachment A, Appendix 14 Request for an Accounting of Disclosure for this purpose.

2. The client may submit instead a written request containing all the elements in Section XIII, Attachment A, Appendix 14.

D. The client submits the request to the Privacy Officer or designee.

E. The Complaint Officer shall respond within 60 days.

4.11.6 Complaints about privacy

A. A client may lodge a complaint about:

1. MHCADSD compliance with HIPAA;

2. MHCADSD privacy policies and procedures; or

3. MHCADSD staff compliance with MHCADSD privacy policies and procedures.

B. Complaints about privacy must be in writing, with the signature of the complainant, contact information for the complainant, and the date of the complaint.

C. The Complaint Officer shall respond to all complaints with:

1. A written acknowledgment of receipt of the complaint, within five days of receipt;

2. A review and investigation of the complaint;

3. A plan of action to prevent any recurrences of problems revealed by the review and investigation; and

4. A final written response to the complainant regarding the disposition of the complaint.

D. In both the acknowledgement letter and the final response, the complainant shall be informed of his/her right to complain directly to the Secretary of Health and Human Services and how to do so.

E. The Complaint Officer shall keep a record of each complaint and its disposition.

F. The Complaint Officer shall report all complaints about a breach of privacy to the Privacy Officer.

G. The Complaint Officer shall prepare a summary of privacy complaints periodically for review by the Privacy Officer and MHCADSD administrative staff.

H. Complaint summaries shall be used to improve personnel training and policies and procedures.

4.11.7 MHCADSD staff shall not retaliate against any client exercising any right regarding his/her PHI allowed under these policies and procedures.

4.11.8 For any mailed correspondence with clients, MHCADSD staff shall use envelopes that do not reference mental illness or substance use.

4.12 Personnel

4.12.1 All MHCADSD staff, volunteers, and student interns shall receive training on the MHCADSD confidentiality and security policies and procedures, appropriate to their role, and complete Section XIII, Attachment A, Appendix 15 Oath of Confidentiality within 30 days of their commencement of work with the county, except under exceptional circumstances.

4.12.2 The completed Oaths shall be forwarded to DCHS Human Resources and maintained in each person's personnel file.

4.12.3 Additional training or reminders shall be provided to staff, volunteers, and student interns:

A. At least annually;

B. Whenever a need becomes apparent; or

C. Whenever significant changes are made to these policies or procedures.

1. When significant changes have occurred, only those staff whose functions are affected need be retained.

2. The retraining shall occur within 30 days after the change becomes effective.

4.12.4 The Privacy Officer is responsible for the content and timely occurrence of all trainings.

4.12.5 Records of trainings shall be kept for at least six years, documenting content and attendees.

A. The Privacy Officer shall maintain documentation of trainings, and

B. Certificates of training completion shall be forwarded to DCHS Human Resources and placed in each person's personnel file.

4.12.6 Staff may report to the Complaint Officer:

A. Any concern with MHCADSD confidentiality and security policies and procedures; or

B. Any failure by MHCADSD staff, volunteers, student interns, or persons outside MHCADSD to follow the MHCADSD confidentiality and security policies and procedures.

4.12.7 MHCADSD shall not retaliate against staff making a complaint or report to the Complaint Officer.

4.12.8 Staff Sanctions

A. Sanction of staff may occur for:

1. Failure to attend required trainings; or

2. Failure to abide by MHCADSD confidentiality and security policies and procedures.

B. Sanction of staff may not occur for:

1. Whistle blowing, as allowed by law;

2. Reporting to law enforcement, as allowed by law, when staff have been victims of crime;

3. Making a complaint to a supervisor or the Complaint Officer;

4. Complaining to the Secretary of Health and Human Services;

5. Participating in an investigation, compliance review, proceeding, or hearing; or

6. Opposing any practice that the staff has a good faith belief is illegal, if the manner of opposition is reasonable.

4.12.9 The staff person's supervisor, and DCHS Human Resources staff, in consultation with the Privacy Officer and in accordance with current King County personnel policies, shall determine appropriate sanctions. Depending on the circumstances, sanctioning may consist of:

A. Required retraining;

B. Formal warning that the staff may lose the privilege of accessing and using confidential information;

C. Loss of the privilege of accessing and using confidential information; or

D. Suspension or termination of employment.

4.12.10 The Privacy Officer shall provide documentation of violations to DCHS Human Resources to be placed in the staff's personnel file.

4.12.11 DCHS Human Resources shall maintain centralized documentation of all sanctions.

4.12.12 Civil penalties may be assessed by the Secretary.

4.12.13 Criminal penalties may be pursued by the federal Department of Justice.

4.13 Research

4.13.1 Access to information may be given in some instances for research and/or evaluation activities, as specified in the MHCADSD Evaluation and Research Committee policies and procedures.

4.13.2 Research that requires disclosure outside of MHCADSD is based on a data sharing agreement that has been approved by the Privacy Officer.

4.13.3 The Privacy Officer may consult with the MHCADSD Privacy and Security Committee prior to approving a data sharing agreement.

4.14 Marketing

As MHCADSD shall not engage in marketing practices, no access, use, or disclosure of protected health information will occur for this purpose.

4.15 Compliance reviews

4.15.1 Reviews by Health and Human Services

A. The Secretary of Health and Human Services may conduct reviews to determine if MHCADSD is complying with federal privacy and security laws.

B. At the request of the Secretary, MHCADSD shall provide all documentation demonstrating compliance in our policies, procedures, and practices.

C. Should a finding occur that MHCADSD is not in compliance, the Privacy Officer shall develop a corrective action plan and implement the needed changes.

4.16 Security of protected health information on paper

4.16.1 Clinical or care management records:

A. Shall reside in a secure designated location at each of the following sites: the Chinook Building, Emergency Services Patrol office, and Harborview Medical Center Psychiatric Emergency Services;

B. Shall include portions of the designated record set as well as information that is not part of the designated record set;

C. Shall include both mental health and substance use disorder protected health information, filed according to the source of the information so that information from mental health providers is separated from information from substance use disorder providers;

D. Shall include all paper files the division has on the client or reference the location of additional paper files; and

E. Shall be locked at the end of the working day, with access by designated staff only. (Services that operate around the clock, such as CCS, may develop other criteria for when paper files need to be locked up.)

4.16.2 Facsimile (fax) machines

A. Protected health information shall be received or sent only on fax machines placed in secure locations.

B. Unless it is a regularly used number, staff shall verify the accuracy of a fax number prior to transmission.

1. When the fax number has been recently received from a reliable source, it can be considered verified.

2. Other fax numbers can be verified by calling the recipient or faxing the recipient a verification request (which contains no PHI).

4.16.3 Shredding

Paper documents to be shredded shall be kept in secured designated areas.

4.16.4 When a breach of PHI (including ePHI) reported to have occurred, the Privacy and/or Security Officer shall investigate the incident and employ appropriate timely actions as established by internal MHCADSD procedure. Additionally, for breaches of ePHI, the requirements of Chapter 42.56 Revised Code of Washington (RCW) shall be followed.

A. The Privacy and/or Security Officer shall make recommendations to the Privacy and Security Committee, and MHCADSD Management Team, as needed, to prevent future breaches of protected health information.

B. When applicable for persons or organizations outside MHCADSD, sanctions for reportable breaches may include termination of access privileges, termination of contracts, fines, and/or criminal prosecution.

5.0 SECURITY POLICY AND PROCEDURES

The HIPAA Security Rule specifically focuses on the safeguarding of electronic protected health information (ePHI). The main goal of the HIPAA Security Rule is to protect the confidentiality, integrity, and availability of ePHI. All covered entities under HIPAA shall comply with the HIPAA Security Rule which established a set of security standards for securing ePHI.

Each security measure of the HIPAA Security Rule can be categorized as being an Administrative, Physical, or Technical safeguard.

Administrative Safeguards

5.1 Security Management Process (§164.308(a)(1))

HIPAA Standard: *Implement policies and procedures to prevent, detect, contain, and correct security violations.*

5.1.1 The Privacy and Security Committee shall periodically identify all database applications that access ePHI.

5.1.2 The Committee will periodically conduct assessments of internal risk. When available, a recent King County-wide vulnerability study shall be used to inform this assessment.

5.1.3 MHCADSD Information System (IS) staff shall use purchased software tools to help identify security violations.

5.2 Assigned Security Responsibility (§164.308(a)(2)

HIPAA Standard: *Identify the security official who is responsible for the development and implementation of the policies and procedures required.*

5.2.1 The MHCADSD Master Database Administrator is the Security Officer.

5.2.2 Security Officer responsibilities are described in part 3.5 of this Section.

5.3 Workforce Security

HIPAA Standard: *Implement policies and procedures to ensure that all members of its workforce have appropriate access to electronic protected health information, as provided under paragraph (a)(4) of this section, and to prevent those workforce members who do not have access under paragraph (a)(4) of this section from obtaining access to electronic protected health information.*

5.3.1 Access to ePHI for MHCADSD staff is determined by the minimum necessary standard in Section XIII, Attachment A, Appendix 4 Maximum Potential Access To and Use of PHI by MHCADSD Staff without Client Authorization or Consent, supervisor approval, professional credentials, job description, and assigned job tasks.

5.3.2 Access to ePHI for persons who are not MHCADSD staff as follows:

A. No persons who are not MHCADSD staff may access SUD PHI without consent or authorization.

B. Persons who are not MHCADSD staff may access electronic MH PHI without consent or authorization as follows:

1. At provider agencies under contract to MHCADSD to provide only mental health services, the following employees may access PHI: mental health professionals or registered counselors for the purpose of providing treatment, or other personnel for the purpose of performing administrative functions such as audits, information management, or program evaluation. Specific access is defined in Section XIII, Attachment A, Appendix 16, Disclosure of the Minimum Necessary Electronic MH PHI to Providers without Client Authorization or Consent

2. At provider agencies under contract to MHCADSD to provide both mental health and substance use disorder treatment, the following employees may access PHI, only those staff who are mental health professionals or licensed mental health counselors, or licensed mental health counselor associates, for the purpose of providing treatment. Specific access is defined in Section XIII, Attachment A, Appendix 16.

5.3.3 Termination of access to ePHI

A. Electronic client information access expires when a person terminates employment, undergoes a change in job responsibilities such that he/she no longer needs that access, and/or loses access privileges due to a failure to adhere to MHCADSD privacy and security policies.

B. Supervisors shall notify the Privacy Officer or designee at least five days before such a change occurs so access may be terminated or revised.

5.4 Information Access Management (§164.308(a)(4))

HIPAA Standard: *Implement policies and procedures for authorizing access to electronic protected health information that are consistent with the applicable requirements of subpart E of this part.*

5.4.1 Persons who require access to electronic client information shall apply in writing.

A. The person completes the application in Section XIII, Attachment A, Appendix 17, Application for Access to Information Systems.

B. The application is reviewed and, if appropriate, approved by the person's immediate supervisor and, if applicable, the site supervisor.

C. The application is submitted to MHCADSD support staff, who log the request into the EAR database, check for initials and appropriate signatures.

D. Support staff will pass along the application to the Privacy Officer or designee for approval.

E. The Privacy Officer will complete the approval process and upon approval, a help desk ticket is created. The Privacy Officer submits the help desk ticket to the King County Information Technology (KCIT) Service Center for processing.

F. The Privacy Officer signs and dates the application, and returns the completed form to the MHCADSD support staff for processing and filing.

G. KCIT Service Center completes the request for electronic access and a resolved help desk ticket is sent to the Privacy Officer. This resolved ticket is automatically forwarded to the MHCADSD support staff to notify first time users and file the completed applications.

5.4.2 State databases

A. For application to access the Department of Social and Health Services (DSHS) MHD Intranet, staff complete Appendix 19 and forward it to IS staff for the appropriate signature. The IS staff will then forward to support staff for processing. The MHD Intranet requires each user to change his/her password every 60 days. DSHS approves each individual application.

B. For application to access the state DBHR's TARGET database, MHCADSD staff obtains the application from the designated support staff person. The state DBHR approves each individual application.

C. For application to access the DSHS ProviderOne web portal, staff completes an electronic access request (EAR) form, entering "ProviderOne" in the section titled "Other." Supervisor and Privacy Officer approve each application.

D. For application to access the DSHS Research and Data Analysis PRISM system, staff complete Appendix 23, and forward it to the MHCADSD Privacy Officer for approval and processing.

5.4.3 Renewal of access privileges for MHCADSD applications

A. Electronic client information access shall be renewed at least annually.

B. Notification for renewal will be sent to each staff 30 days prior to expiration.

C. To renew access, all procedures in 5.4.1 are repeated.

5.4.4 Termination of access privileges

A. To terminate access, Section XIII, Attachment A, Appendix 17, Application for Access to Information Systems is submitted by the employee or his/her supervisor to the Privacy Officer, who will process the termination.

B. Termination of access is tracked in the electronic access request (EAR) database.

5.5 Security Awareness and Training (§164.308(a)(5))

HIPAA Standard: *Implement security awareness and training program for all members of its workforce (including management).*

5.5.1 Policies and procedures for the training of all staff on privacy and security are found in part 4.12 of this section.

5.5.2 MHCADSD staff shall receive technical training as needed to implement the technical security safeguards.

5.6 Security Incident Procedures (§164.308(a)(6))

HIPAA Standard: *Implement policies and procedures to address security incidents.*

A security breach for ePHI shall be addressed as described in 4.16.4 of this section and in accordance with KCIT Security and Privacy policies as adopted by the County and approved by the County Chief Information Security Officer (available at http://kcweb.metrokc.gov/oirm/policies.aspx)

5.7 Contingency Plan (§164.308(a)(7))

HIPAA Standard: *Establish (and implement as needed) policies and procedures for responding to an emergency or other occurrence (for example, fire, vandalism, system failure, and natural disaster) that damages systems that contain electronic protected health information.*

5.7.1 Data Backup

A. KCIT Backup Services shall perform daily backups of the network and database servers. Weekly full backups of the network and database servers are kept off-site for one year and the tapes encrypted using National Institute Standards and Technology (NIST) standards.

B. The most recent backup tapes shall be transported to an off-site facility at least three times per week.

5.7.2 Disaster recovery plan for ePHI

A. The MHCADSD Emergency/Disaster Recovery Plan is found in the MHCADSD Internal Policy Manual.

B. Data and system recovery backup tapes shall be tested at least annually to ensure backup media and hardware integrity.

5.7.3 Emergency mode operations

A. CCS is the critical MHCADSD business unit.

B. When ePHI is not available for CCS use, paper files shall be used.

5.8 Evaluation (§164.308(a)(8))

HIPAA Standard: *Perform a periodic technical and non-technical evaluation, based initially upon the standards implemented under this rule and subsequently, in response to environmental or operational changes affecting the security of electronic protected health information that establishes the extent to which an entity's security policies and procedures meet the requirements of this subpart.*

5.8.1 The Privacy and Security Committee shall conduct an annual review of the Confidentiality and Security policies and procedures in response to environmental or operational changes affecting the security of ePHI.

5.8.2 The review shall use a standardized risk assessment tool developed in conjunction with the King County Designated Health Care Components (DHCC) workgroup.

5.9 Business Associate Agreements and Other Arrangements (§163.308(b)(1))

HIPAA Standard: *A covered entity, in accordance with Sec. 164.306, may permit a business associate to create, receive, maintain, or transmit electronic protected health information on the covered entity's behalf only if the covered entity obtains satisfactory assurances, in accordance with Sec. 164.314(a) that the business associate appropriately safeguard the information.*

5.9.1 Each MHCADSD contract shall contain boilerplate language incorporating the requirements for business associates described in part 4.10.

5.9.2 Contractors are required to pass down these requirements to any subcontractors.

5.9.3 Boilerplate language shall be updated whenever changes in laws require it.

Physical Safeguards

5.10 Facility Access Controls

HIPAA Standard: *Implement policies and procedures to limit physical access to its electronic information systems and the facility or facilities in which they are housed, while ensuring that properly authorized access is allowed. (Note: Supports the Information Access Management Administrative Standard and the Access Control Technical Standard.)*

5.10.1 Physical security shall be maintained at all sites by the use of locked doors (either combination or keyed locks) where feasible.

A. Key distribution shall be monitored to ensure physical security.

1. Keys shall be given to staff only when required to fulfill a job responsibility.

2. Keys shall be retrieved from staff whenever that person leaves MHCADSD employment or job responsibilities no longer require key access.

3. Keys shall be changed as often as necessary to ensure physical security.

4. Detailed procedures for the distribution of keys are found in the MHCADSD Internal Policy Manual and DCHS policies.

B. Electronic information systems shall be kept behind locked, unlabeled doors.

5.10.2 When doors must remain unlocked, a receptionist shall be available to authorize entry to secure areas. Entry shall be granted as follows:

A. King County employees who are displaying ID badges issued by King County staff shall be permitted to enter on request.

B. All other visitors, and King County employees who do not display a King County ID badge must sign in and out at the reception desk and wear a visitor ID badge while on the floor.

C. Visitors coming to see a specific staff person shall be accompanied to and from that staff person's office by an MHCADSD employee, unless the employee waives that requirement as the person is well known and felt to be low risk.

5.10.3 Facility areas in which PHI is most readily available shall have additional security barriers, such as a sign stating "Designated Personnel Only Beyond This Point."

5.10.4 Data wiring closet access is limited to building management and designated personnel, according to job function.

5.10.5 Physical maintenance records impacting physical security shall be maintained by the DCHS or building management.

5.11 Workstation Use (§164.310(b))

HIPAA Standard: *Implement policies and procedures that specify the proper functions to be performed, the manner in which those functions are to be performed, and the physical attributes of the surroundings of a specific workstation or class of workstation that can access electronic protected health information.*

5.11.1 KCIT shall maintain and inventory of workstations and County-owned portable devices and either their locations within the MHCADSD facilities or the staff person to which they are assigned.

5.11.2 The functions of any workstation shall be determined by the job responsibilities and access rights of the staff person to which it is assigned. Workstations may be used only for work-related activities.

5.11.3 Workstations within cubicles or offices must be physically located to minimize the viewing of PHI by any passers-by. This also applies to workstations at all MHCADSD remote sites.

5.12 Workstation Security (§164.310(c))

HIPAA Standard: *Implement physical safeguards for all workstations that access electronic protected health information, to restrict access to authorized users.*

5.12.1 On-site workstations shall comply with 5.11.3 above.

5.12.2 At home:

A. The computer should be physically located to minimize the viewing of PHI by other residents or visitors to the home.

B. MHCADSD user log-in IDs and passwords shall be kept private from other home computer users.

C. ePHI data files shall not be copied to any home computer hard drive.

5.12.3 In ESP vans

A. Laptops shall be secured into van workstations.

B. The computer screen should be physically oriented to minimize the viewing of PHI by clients in the van.

C. MHCADSD user log-in IDs and passwords shall be kept private from clients.

D. Current county-approved secure encrypted network tunnel shall be used.

E. All policies related to laptops, notebooks, and tablet computers apply.

5.13 Device and Media Controls (§164.310(d)(1))

HIPAA Standard: *Implement policies and procedures that govern the receipt and removal of hardware and electronic media that contain electronic protected health information into and out of a facility, and the movement of these items within the facility.*

5.13.1 When MHCADSD staff transport media with PHI, it shall either be kept in a secured area or in the presence of the MHCADSD staff person.

5.13.2 Couriers

A. Only approved couriers may be used.

B. Media containing protected health information must be placed in secure containers for courier transport and marked confidential.

C. Signatures must be obtained upon delivery of PHI. No PHI may be left without a signature from the recipient.

5.13.3 Delivery services

A. For FedEx deliveries, return receipt signatures must be requested.

B. For USPS, “signature confirmation” and “return receipt” shall be requested at the post office.

C. UPS shall not be used for delivery of PHI.

5.13.4 Staff may not put ePHI on personally owned portable devices including, but not limited to handhelds/PDAs, Ultramobile PCs, flash memory device (e.g., USB flash drives, personal media players/recorders), portable hard disks, cell phones, CDs, disks, DVDs, and laptop/notebook computers.

A. Any staff person who wants to download his/her e-mail messages.

1. Personally owned portable devices or cell phones must be password-protected.

2. Encrypted email must not be opened on personally owned devices.

B. ePHI shall not be sent via wireless networks unless pre-approved by the Privacy and Security Committee.

C. Staff who have remote access (e.g., Citrix), may not use email encryption unless the software application is installed on their office workstation.

5.13.5 All County-owned portable equipment, such as a laptop/notebook/tablet computers shall be encrypted in accordance with requirements in the KCIT policies. Additionally, the following shall occur:

A. All laptop/notebook/tablet computers shall require a password to be booted up.

B. Leaving a laptop/notebook/tablet computer unattended in a vehicle is forbidden.

C. ePHI shall not be sent via wireless networks unless pre-approved by the Privacy and Security Committee.

5.13.6 MHCADSD staff shall not copy ePHI to county-owned portable devices including, but not limited to handhelds/PDAs, Ultramobile PCs, flash memory device (e.g., USB flash drives, media players/recorders), portable hard disks, cell phones, CDs, disks, DVDs, and laptop/notebook computers. without the approval of the Security Officer.

5.13.7 PHI on portable media created for delivery outside of MHCADSD shall be encrypted.

A. The encryption code shall not be transported or delivered on the same media or in the same package as the media containing the PHI.

B. The media shall be labeled “Contains confidential health care information” and “if found, return to MHCADSD” with MHCADSD mailing address.

C. The procedure for creating the disk is in Section XIII, Attachment A, Appendix 18, MHCADSD Procedure for Making a CD Containing PHI.

5.13.8 The KCIT Data Center will be responsible for hard drive destruction for the servers in the standard virtual environment (SVE).

A. Hard drives for reuse shall be reformatted.

B. Hard drives for disposal shall be physically crushed and/or degaussed.

C. CDs, DVDs, and back-up tapes shall be cut, scratched, shredded, or otherwise destroyed.

5.13.9 Records on the disposal (including equipment donation) of ePHI equipment and media shall be maintained for at least six years.

Technical Safeguards

5.14 Access Controls (§164.212(a)(1))

HIPAA Standard: *Implement technical policies and procedures for electronic information systems that maintain electronic protected health information to allow access only to those persons or software programs that have been granted access rights as specified in Sec. 164.308(a)(4). (Note: Supports the Information Access Management Administrative Standard and Facility Access Controls Physical Standard.)*

5.14.1 MHCADSD will comply with KCIT policies. These policies have been reviewed and adopted by the county and approved by the County Chief Information Security Officer and are available at http://kcweb/oirm/policies.aspx

5.14.2 See section 4.5 above on Minimum Necessary for a description of the policy and procedures describing in what conditions a person may have access to PHI and how such access is granted.

5.14.3 Each approved MHCADSD information system user shall be assigned a unique network and database login user ID.

5.14.4 Each approved user shall have a password, which shall be:

A. At least eight characters long. Additional strong password format requirements shall be implemented based on the capability of the network server and database server.

B. Changed at least every 90 days.

C. Expired if not changed or used in 90 days.

D. Not disclosed to other persons.

5.14.5 Logins

A. After three unsuccessful login attempts to the network, the user shall be denied access to the network for 15 minutes.

B. Unsuccessful login attempts shall be tracked and monitored.

C. For remote logins, automatic log off shall occur after 45 minutes for providers and two hours for MHCADSD staff.

D. Each MHCADSD and provider staff person shall be held accountable for all access to MHCADSD databases gained through the use of that staff person's unique user login identification code and password.

5.14.6 Log outs

A. Password-protected screen savers in cubicles or multi-staff areas shall be activated to come on after five minutes of no use.

B. Password-protected screen savers in enclosed offices shall be activated to come on after no more than fifteen minutes of no use.

C. Staff shall log off and shut down all workstations and equipment at the end of their working day, unless otherwise directed.

5.15 Audit Controls (§164.312(b))

HIPAA Standard: *Implement hardware, software, and/or procedural mechanisms that record and examine activity in information systems that contain or use electronic protected health information.*

5.15.1 Access by individuals to all applications containing ePHI shall be monitored. Information collected shall include the identity of the individual, the name of the application, and the entry and exit times to the application.

5.15.2 From this information, the Privacy and Security Committee shall regularly review reports looking at the following:

A. Large total hours of access in a day to applications containing ePHI;

B. More than one access at the same time to any given application by the same individual; and

C. Access to applications before 7 a.m. or after 6 p.m. by persons whose work responsibilities are unlikely to require such access.

5.16 Integrity (§164.312c)c)1))

HIPAA Standard: *Implement policies and procedures to protect electronic protected health information from improper alteration or destruction.*

5.16.1 Security measures to protect ePHI from improper alteration and destruction shall include:

A. Access to software that allows the addition, alteration, or destruction of ePHI shall be limited to those persons who require these functions to fulfill their job responsibilities.

B. PHI submitted electronically by batch shall be validated according to the business rules in the KCMHP Data Dictionary and the KCMHP Policy and Procedure Manual. Submitted data that cannot be validated will be rejected and the provider submitting the data will be alerted via an error report of the need to correct and resubmit.

C. Malicious software protections

1. KCIT shall maintain the latest protection from malicious software (anti-virus, anti-worm, etc.) on the network and on individual workstations.

2. Providers with access to MHCADSD databases shall also maintain the latest protection from malicious software on networks and individual workstations.

3. MHCADSD employees shall not download software or any other items off the internet onto a MHCADSD workstation without pre-approval by KCIT.

4. MHCADSD employees shall install no software nor use any devices at MHCADSD workstations without pre-approval by KCIT.

5. Only Microsoft Windows screensavers may be used. A staff may use his/her own photographs on a screensaver by either emailing the photograph to his/her workstation or installing the photography from a dish that IS staff have scanned prior to the installation.

D. A firewall is maintained and administered for all county functions by the KCIT.

5.17 Person or Entity Authentication (§164.312(d))

HIPAA Standard: *Implement procedures to verify that a person or entity seeking access to electronic protected health information is the one claimed.*

5.17.1 Each provider staff person application for access shall be authenticated by use of an official site supervisor list of those who can sign applications for each provider site.

5.17.2 MHCADSD shall use passwords as the primary means to validate user identity. Passwords are required to access the Novell network and any application that accesses PHI.

5.17.3 All passwords will adhere to the policies described in section 6.14 Access Controls.

5.18 Transmission Security ((§164.312(e)(1))

HIPAA Standard: *Implement technical security measures to guard against unauthorized access to electronic protected health information that is being transmitted over an electronic communications network.*

5.18.1 A provider may use only MHCADSD-approved software for the transmission of ePHI over a public network.

5.18.2 All data transmission software shall provide the ability to encrypt data before transmission.

5.18.3 ePHI data transmitted between the Washington State Department of Department of Social and Health Services and/or Health Care Authority, and MHCADSD shall be done using software specified by the state.

6.0 LIST OF APPENDICES:

6.1 Appendix 1 Designated Record Set

6.2 Appendix 2 Limited Data Set

6.3 Appendix 3 Consent/Authorization for Release of Information

6.4 Appendix 4 Maximum Potential Access to and Use of PHI by MHCADSD Staff without Client Authorization/Consent

6.5 Appendix 5 Routine Disclosures of PHI by MHCADSD Staff

6.6 Appendix 6 Redisclosure of Enrollment Information without Client Consent

6.7 Appendix 7 Request for Client Information without Authorization

6.8 Appendix 8 Form of Invalid Authorizations

6.9 Appendix 9 Request to Communicate by Alternative Means

6.10 Appendix 10 Log of Disclosures without Client Consent or Authorization

6.11 Appendix 11 Request to Revoke Consents

6.12 Appendix 12 Request to Amend or Correct PHI

6.13 Appendix 13 Request to Restrict Access, Use or Disclosure of PHI

6.14 Appendix 14 Request for an Accounting of Disclosures

6.15 Appendix 15 Oath of Confidentiality

6.16 Appendix 16 Disclosure of Minimum Necessary Electronic MH PHI to Providers

6.17 Appendix 17A Application for Access to Electronic Information Systems (Providers)

6.18 Appendix 17B Application for Access to Electronic Information Systems (MHCADSD)

6.19 Appendix 18 MHCADSD Procedure for Making a CD containing PHI

6.20 Appendix 19 DSHS Oath of Confidentiality

6.21 Appendix 20 Business Associate Agreement

6.22 Appendix 21 Data Sharing Agreement

6.23 Appendix 21-A: Data Security Requirements

6.24 Appendix 21-B: Data Disposition Certification

6.25 Appendix 21-C: Research and Evaluation Oath of Confidentiality

6.26 Appendix 22 Data Sharing Agreement for Limited Data Set

6.27 Appendix 23 DSHS PRISM Registration Form

7.0 REFERENCES:

Federal Law, Regulations, and Policy including any successor, amended, or replacement laws, regulations**,** or policies

- 42 CFR Part 2 Confidentiality of Alcohol and Drug Abuse Patient Records
- 45 CFR Part 46 Protection of Human Subjects
- 45 CFR Parts 160 Public Welfare and Human Service – General Administrative Requirements
- 45 CFR Parts 162 Public Welfare and Human Service – Administrative Requirements
- 45 CFR Part 164 Public Welfare and Human Service – Security and Privacy

Washington State Law, Regulations, and Policy including any successor, amended, or replacement laws, regulations, or policies

- Chapter 388-04 WAC – Department of Social and Health Services – Protection of Human Research Subjects
- Chapter 388-877B WAC – Certification Requirements for Chemical Dependency Treatment Service Providers
- Chapters 388-865, 388-877, 388-877A WAC – Department of Social and Health Services – Mental Health – Community Mental Health and Involuntary Treatment Programs
- Chapter 10.77 RCW – Criminal Procedure – Criminally Insane

- Chapter 13.50 RCW – Juvenile Courts and Juvenile Offenders – Keeping and Release of Records by Juvenile Justice or Care
- Chapter 42.56 RCW – Public Officers and Agencies – Public Records Act
- Chapter 70.02 RCW – Public Health and Safety – Medical Records – Health Care Information Access and Disclosure
- Chapter 70.96A RCW – Public Health and Safety – Treatment for Alcoholism, Intoxication and Drug Addiction
- Chapter 71.05 RCW – Mental Illness – Mental Illness
- Chapter 71.24 RCW – Mental Illness – Community Mental Health Services Act
- Chapter 71.34 RCW – Mental Illness – Mental Health Services for Minors

Other

- Evaluation and Research Committee, MHCADSD Policies and Procedures, Section XIII, Attachment B

Designated Record Set

The following protected health information (PHI) comprises the MHCADSD designated record set.

1. Treatment information:

    - Clinical and legal records kept by the Assessment Center, Crisis and Commitment Services, Chemical Dependency Involuntary Treatment Services; and

    - Clinical records that also include information on individual clients related to client outcomes or services in other systems, such as the jail and juvenile detention files and information on individual admissions to Western State Hospital.

2. Payment information:

    - Medicaid, Disability Lifeline, or ADATSA eligibility or other financial eligibility data;

    - Enrollment in a treatment program; and

    - Billing and payment records, if the client is identified on an invoice.

3. Health care operations information:

    - Information obtained or documented for care authorization purposes, such as outpatient benefit authorizations, hospital authorizations (including extension reviews, appeals, etc), Medicaid Personal Care authorizations, and Extraordinary Treatment Plans authorizations;

    - Information obtained or documented in the process of addressing client complaints, grievances, and hearings and in reviewing extraordinary occurrences, when the review contributes to decisions made about the client(s) involved;

    - Information obtained or documented by staff to monitor the division-funded programs for mentally ill offenders; and

    - All PHI collected in the course of an agency audit, when the audit contributes to decisions made about the client(s) involved.

    The MHCADSD designated record set does not include PHI in extraordinary occurrences or agency audit documents, when the information is or has not been used to make a decision about the individual client.

Limited Data Set, from 45 Code of Federal Regulations Part 164.514(e) HIPAA

(1) *Standard: Limited data set.* A covered entity may use or disclose a limited data set that meets the requirements of paragraphs (e)(2) and (e)(3) of this section, if the covered entity enters into a data use agreement with the limited data set recipient, in accordance with paragraph (e)(4) of this section.

(2) *Implementation specification: Limited data set.* A limited data set is protected health information that excludes the following direct identifiers of the individual or of relatives, employers, or household members of the individual:

(i) Names;

(ii) Postal address information, other than town or city, state, and zip code;

(iii) Telephone numbers;

(iv) Fax numbers;

(v) Electronic mail addresses;

(vi) Social security numbers;

(vii) Medical record numbers;

(viii) Health plan beneficiary numbers;

(ix) Account numbers;

(x) Certificate/license numbers;

(xi) Vehicle identifiers and serial numbers, including license plate numbers;

(xii) Device identifiers and serial numbers;

(xiii) Web Universal Resource Locators (URLs);

(xiv) Internet Protocol (IP) address numbers;

(xv) Biometric identifiers, including finger and voice prints; and

(xvi) Full face photographic images and any comparable images.

(3) *Implementation specification: Permitted purposes for uses and disclosures.*

(i) A covered entity may use or disclose a limited data set under paragraph (e)(1) of this section only for the purposes of research, public health, or health care operations[1].

(ii) A covered entity may use protected health information to create a limited data set that meets the requirements of paragraph (e)(2) of this section, or disclose protected health information only to a business associate for such purpose, whether or not the limited data set is to be used by the covered entity.

[1] Revised Code of Washington (RCW) 70.02.050 further limits the use of a limited data set. IRB approval is required for all research disclosures including limited data sets (RCW 70.05.050(g)(v)). For public health and health care operations, disclosures are limited by RCW 70.02.050(2)(a) and RCW 70.02.050(1)(b) respectively.

(4) *Implementation specifications: Data use agreement.*

(i) *Agreement required.* A covered entity may use or disclose a limited data set under paragraph (e)(1) of this section only if the covered entity obtains satisfactory assurance, in the form of a data use agreement that meets the requirements of this section, that the limited data set recipient will only use or disclose the protected health information for limited purposes.

(ii) *Contents.* A data use agreement between the covered entity and the limited data set recipient must:

(A) Establish the permitted uses and disclosures of such information by the limited data set recipient, consistent with paragraph (e)(3) of this section. The data use agreement may not authorize the limited data set recipient to use or further disclose the information in a manner that would violate the requirements of this subpart, if done by the covered entity;

(B) Establish who is permitted to use or receive the limited data set; and

(C) Provide that the limited data set recipient will:

(*1*) Not use or further disclose the information other than as permitted by the data use agreement or as otherwise required by law;

(*2*) Use appropriate safeguards to prevent use or disclosure of the information other than as provided for by the data use agreement;

(*3*) Report to the covered entity any use or disclosure of the information not provided for by its data use agreement of which it becomes aware;

(*4*) Ensure that any agents, including a subcontractor, to whom it provides the limited data set agrees to the same restrictions and conditions that apply to the limited data set recipient with respect to such information; and

(*5*) Not identify the information or contact the individuals.

(iii) *Compliance.*

(A) A covered entity is not in compliance with the standards in paragraph (e) of this section if the covered entity knew of a pattern of activity or practice of the limited data set recipient that constituted a material breach or violation of the data use agreement, unless the covered entity took reasonable steps to cure the breach or end the violation, as applicable, and if such steps were unsuccessful:

(*1*) Discontinued disclosure of protected health information to the recipient; and

(*2*) Reported the problem to the Secretary.

(B) A covered entity that is a limited data set recipient and violates a data use agreement will be in noncompliance with the standards, implementation specifications, and requirements of paragraph (e) of this section.

King County

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
King County Mental Health, Chemical Abuse and Dependency Services Division
The Chinook Building, 401 Fifth Ave, Suite 400, Seattle, WA 98104
FAX: 206-205-1634

Name: _____ **DOB:** _____ **Previous Name:** _____

By signing below, I authorize the information specified below to be disclosed/released between:

King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD)

AND

_____
Name of Facility/Organization *Name of Person*

_____
Street Address *City/Zip*

_____
Phone *Email* *Fax*

Purpose of the disclosure: _____

Specific information to be disclosed/released (*include date range and other specifics*):

- ☐ This signed authorization form
- ☐ Current and past mental health treatment programs, with dates
- ☐ Current and past substance use disorder treatment programs, with dates
- ☐ Past or present mental health problems or diagnoses
- ☐ Past or present chemical dependency problems or diagnoses
- ☐ Past or present physical health problems
- ☐ Other (specify): _____
  _____

By signing this form, I understand:

- When I am asked to fill out this authorization, I am entitled to a copy.
- I have the right to revoke this authorization at any time. It must be in writing and sent to the Privacy Officer, 401 Fifth Ave, Suite 400, Seattle, WA 98104. Any revocation will not affect any actions already been taken based on the original authorization.
- Without my express revocation, this authorization will expire (insert date or event, invalid if left blank)_____; unless I am under the supervision of the Washington State Department of Corrections, then this authorization will expire at the end of the term of supervision.
- The information disclosed may contain information on my current/past: Mental health, and/or drug or alcohol use, and I authorize the disclosure for the purposes of this authorization.
- Once your health information has been disclosed, the law does not always require the receiver of your information to keep your information confidential.
- I can refuse to sign this form if this authorization is to release information for a purpose other than treatment or the payment for my treatment. If I do refuse to sign, a health care entity may not refuse to provide me with treatment, payment, or access to services because of my refusal to sign.

Signature *(Client or Person Authorized to Give Authorization)*	***Date***
If Signed by person Other Than the Client, Print Name, Provide Reason, relationship to the Client, Description of Their Authority	

FOR INTERNAL USE ONLY

Identity of client verified by: _____

If signed by a legal representative, authority verified by: _____

Date of disclosure/release:_____

MHCADSD staff person making the disclosure/release:_____

Means of disclosure/release (*phone, mail, email, fax, etc.*):_____

Description of PHI disclosed/released:_____

_____

King County

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

King County Mental Health, Chemical Abuse & Dependency Services Division
The Chinook Building, 401 Fifth Ave, Suite 400, Seattle, WA 98104
FAX: 206-205-1634

Name: _____ **DOB:** _____ **Previous Name:** _____

By signing below, I authorize the information specified below to be disclosed/released between:

King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD)

AND

Person _____ Facility/Organization _____ Address_____	Phone_____ Fax _____
AND	
Person _____ Facility/Organization _____ Address_____	Phone_____ Fax_____
AND	
Person _____ Facility/Organization _____ Address_____	Phone_____ Fax_____

Purpose of the disclosure: _____

Specific information to be disclosed/released (*include date range and other specifics*):

- ☐ This signed authorization form
- ☐ Current and past mental health treatment programs, with dates
- ☐ Current and past substance use disorder treatment programs, with dates
- ☐ Past or present mental health problems or diagnoses
- ☐ Past or present chemical dependency problems or diagnoses
- ☐ Past or present physical health problems
- ☐ Other (specify): _____ _____

By signing this form, I understand:

- When I am asked to fill out this authorization, I am entitled to a copy.
- I have the right to revoke this authorization at any time. It must be in writing and sent to the Privacy Officer, 401 Fifth Ave, Suite 400, Seattle, WA 98104. Any revocation will not affect any actions already been taken based on the original authorization.
- Without my express revocation, this authorization will expire (insert date or event, invalid if left blank)_____; unless I am under the supervision of the Washington State Department of Corrections, then this authorization will expire at the end of the term of supervision.
- The information disclosed may contain information on my current/past: Mental health, and/or drug or alcohol use, and I authorize the disclosure for the purposes of this authorization.
- Once your health information has been disclosed, the law does not always require the receiver of your information to keep your information confidential.
- I can refuse to sign this form if this authorization is to release information for a purpose other than treatment or the payment for my treatment. If I do refuse to sign, a health care entity may not refuse to provide me with treatment, payment, or access to services because of my refusal to sign.

Signature *(Client or Person Authorized to Give Authorization)*	***Date***
If Signed by person Other Than the Client, Print Name, Provide Reason, relationship to the Client, Description of Their Authority	

FOR INTERNAL USE ONLY

Identity of client verified by: _____

If signed by a legal representative, authority verified by: _____

Date of disclosure/release:_____

MHCADSD staff person making the disclosure/release:_____

Means of disclosure/release (*phone, mail, email, fax, etc.*):_____

Description of PHI disclosed/released:_____

_____

Maximum potential access to and use of PHI by MHCADSD staff without client authorization or consent*

	Mental Health		Substance Use Disorders	
	Paper	Electronic	Paper	Electronic
Management Team	All	All**	All	All**
Chinook Building Support Staff	All except CCS	All except LOLA	All except ESP	All except SUDITS and ESP
Confidential Secretaries	All except CCS	All	All except ESP	All except ESP
Privacy Officer	All	All	All	All
Emergency Services Patrol	None	None	ESP log	ESP, Sobering, SUDITS
CCAP	None	(These staff may have ECLS "click through" access with ROI.)	CCAP files	
Substance Use Disorders Involuntary Treatment Services	None	(These staff may have ECLS "click through" access with ROI.)	SUDITS files	Sobering, SUDITS
Crisis and Commitment Services	CCS clinical and legal files	CLS, ECLS, Inpatient, and LOLA	None	None
Crisis and Commitment Services court scheduler	CCS clinical and legal files related to current case	LOLA	None	None
SUD assessor at jail	None	(These staff may have ECLS "click through" access with ROI.)	Own files	
Psychiatric Emergency Service	None	CTU (These staff may have ECLS "click through" access with ROI.)	ROI file	SUDITS, Sobering
Information Services	Reports related to IS support function	All	Reports related to IS support function	All
Mental Health Contract Specialists	Chinook Building MH clinical files (records related to audits, complaints and grievances, ETP, inpatient stays, MPC, FIRST, RORS, ORCSP, 3B authorizations), EOs, invoice backup documents	CLS, ECLS, EO, and Inpatient	Audit records	EO

	Mental Health		Substance Use Disorders	
	Paper	Electronic	Paper	Electronic
Substance Use Disorders Contract Specialists	Audit records	None	Audit records, complaints and grievances, EOs, invoice backup documents	EO, CDCT, CDIP
Substance Use Disorders Records Custodian	None	None	All	CHAT
Housing and Vocational Specialist	Records needed to solve individual client housing problems	ECLS	None	None
Compliance Specialist (Managed Care Specialist)	None	CLS and ECLS	None	None
Financial Staff	Invoices	ORCSP fiscal spreadsheet, CLS, ECLS, Inpatient, kid residential and diversion beds fiscal spreadsheet, LOLA, MPC, Transition Utilization Plan, MAA 270/271	Invoices, lists of clients using vouchers	None
Medical Director	Chinook Building MH clinical files, EOs	CLS, ECLS, EO, Hospital appeals, Inpatient, LOLA, 3B appeals, MAA 270/271	EOs, audit records AC	EO
Clinical Specialist, Care Authorizers, and Care Managers	Chinook Building MH clinical files, EOs	ORCSP, Client services, CLIP, CLS, ECLS, EO, Inpatient, MPC, RORS, PACE, 3B appeals, 3B case rate change, MAA 270-271	None	None
SPE	None	All	None	All
Quality Review Team	None	None	None	None
Client Services Staff	Chinook Building MH clinical files	ORCSP, Client services, CLIP, CLS, ECLS, EO, Inpatient, MPC, RORS, PACE, 3B appeals, 3B case rate change	None	EO
Criminal Justice Initiatives Coordinator and	CJ files	ECLS	CJ files	

	Mental Health		Substance Use Disorders	
	Paper	Electronic	Paper	Electronic
Researcher				
Children's Planner	Chinook Building MH clinical files, EOs	Client services, CLIP, CLS, ECLS, EO, Inpatient, 3B appeals, 3B case rate change, MAA 270-271	None	None
Prevention Staff	None	None	None	None
Grant/Project Coordinator	None	None	None	None

*Actual access and use is further restricted to protected health information that each staff person requires for the performance of his/her assigned tasks as defined and approved by his/her supervisor

**Electronic information

MH PHI from "PHP 96" (the mental health database)
- Client services (track MH client complaints)
- CLS (view and update options)
- CTU
- ECLS
- Inpatient (view and update options)
- LOLA (used by Crisis and Commitment staff) (view and update options)

MH PHI on the I drive (clinical team)

MH PHI on the J drive (financial team)

CD PHI
- CDITS (persons referred for CD involuntary treatment) (view and update options)
- CHAT (look-up, for records retrieval)
- ESP (log of persons transported by ESP van) (view and update options)
- Sobering (persons served at the Sobering Center) (view and update options)
- Target Extract (info on King County residents downloaded from the state's TARGET database)

CD and MH combined PHI
- EO

Routine disclosure of PHI by MHCADSD staff without client authorization or consent*

MASTER LIST (7.07.08)

	MH Data disclosed TO Agency	**Specific MH Information Disclosed**[1]	**SUD Data Disclosed TO Agency**	**Specific SUD Information Disclosed**
A-Team	A Team consists of DDD, Harborview social worker, other hospitals such as UW, HRSA, WSH, Aging and Disability Services, Residential Care Service, ACS, police may be there	Nothing without an ROI (Treatment planning, but ROI needed to share information with non-Health care professionals. A release must cover every person in the room.)		
A-Team –like programs (Clinical SPE)	Providers Others	Nothing without an ROI	None	None
All health care professionals	Child Protective Services Adult Protective Services Long-term care Ombuds	Minimum necessary to report abuse as required by law	Child Protective Services Adult Protective Services	Minimum necessary to report abuse as required by law. For reports on adult abuse, need a consent or need to report in such a way that the fact of the client's substance use is not disclosed
AOD Prevention Staff	None		None	
C-CORS Program Manager	All with ROI except case staffings	For case staffings, treatment status, assessments, planning, discharge info, extension requests	All with ROI	
SUD Assessment Staff at RJC	None		Substance Use Disorder agencies	Nothing without an ROI. For the purposes of treatment, assessments; TARGET and ASAM data

[1] Disclosure, for purposes of payment and health care operations is subject to application of the minimum necessary requirements of HIPAA, that is, provision of the minimum information necessary to the purpose for which the information is made available. Disclosure for health oversight activities must be required by law and limited to the "relevant requirements of such law."164.512(a)

	MH Data disclosed TO Agency	**Specific MH Information Disclosed[1]**	**SUD Data Disclosed TO Agency**	**Specific SUD Information Disclosed**
SUD Contract Specialists	None	None	Contracted providers	Any information needed to monitor a contract. Authority is Health Care Oversight.
Substance Use Disorder Involuntary Services	None without consent/ authorization	None without consent/authorization	Prosecutors, Court[2]	Name, demographic information, contact people, medical history (as needed), use of services, or declarations. Authority is Revised Code of Washington (RCW) 70.96A.140
Chinook Building Support Staff	(Only on the request of others on this list)	No routine disclosures	(Only on the request of others on this list)	No routine disclosures
Clinical Specialists, Care Authorizers, Care Managers, and Client Services	Department of Juvenile Rehabilitation Administration	Receive referral information and would re-release the information to KCMHP providers. (This may include SUD treatment information).		
	Department of Children and Family Services	Enrollments status, participate in specific case staffing Diagnosis Inpatient service information Outpatient service information		
	Division of Developmental Disabilities Division of Vocational Rehabilitation	Enrollment status, participate in specific case staffing Diagnosis Inpatient service information Outpatient service information		
	Local hospitals	Enrollment status, participate in specific case staffing Outpatient service information		
	Outpatient providers Subcontractors and Carve Out Providers	Clinical Information Participate in specific case staffing Outpatient service information		
	CLIP	Enrollment status, participate in		

[2] RCW 70.96A.140

	MH Data disclosed TO Agency	**Specific MH Information Disclosed[1]**	**SUD Data Disclosed TO Agency**	**Specific SUD Information Disclosed**
	WSH	specific case staffing		
	Department of Mental Health, Center for Medicaid and Medicare Services, HRSA, and King County Ombuds	Client specific clinical information Diagnosis Inpatient service information Outpatient service information		
	King County Superior Court Department of Adult and Juvenile Detention	Enrollment status and provider Diagnosis Inpatient service information Outpatient service information		
CLIP Workgroup	CLIP Workgroup consists of MHCADSD staff, DCFS, 2 IST Coordinators, providers and parents of children formerly in CLIP	System oriented – to make recommendations. PHI not discussed. Will use general terms rather than specifying individual clients by name or other identifier	None	None
Community Organizer	None		None	
Compliance Specialist	Department of Correction (DOC) Prison personnel (risk managers, treatment staff); DOC headquarter staff (personnel associated with mentally ill offender projects);	Enrollment information Provide information related to individuals who may be/are served through mentally ill offender initiatives for planning purposes and coordination. Authority is HIPAA section 164.512(k)(5) that allows sharing of information while client is incarcerated and 70.02 RCW	None	None
Confidential Secretaries	(Only on the request of management)	No routine disclosures	(Only on the request of management)	No routine disclosures
Crisis and Commitment Services[3] (including court scheduler)	Treatment providers, including outpatient and inpatient, public and private	When they call to refer or consult, may discuss DOB, next of kin, current provider, medication, hx of danger, hx of tx. Authority is 70.02 RCW.	None except with consent or as permitted by 42 Code of Federal Regulations Part 2	Information specified in consent.

[3] Most covered by RCW 71.05.390 and 71.05.630

	MH Data disclosed TO Agency	**Specific MH Information Disclosed[1]**	**SUD Data Disclosed TO Agency**	**Specific SUD Information Disclosed**
	Superior/district/ municipal courts, prosecuting attorney, public defender, court monitor (if MH court), WSH Center for Forensic Services	Report in event of a dismiss & detain court order, whether found a mental disorder and what the disposition was. Authority is Chapter 10.77 RCW.		
	WSH Center for Forensic Services	For the purpose of treatment, hx of tx, current provider		
	DSHS/WSH	DOB, hospital detained to and why detained, for purpose of obtaining a one-bed certification. Authority is Chapter 70.02 RCW.		
	MH Court monitor and mental health liaison (SMH employee)	If history of danger or detentions. Requires consent or must meet the requirements of 164.512(e)(1)(iii) requires documenting on the accounting form. Purpose is arranging court ordered treatment (not the same as just "treatment"). Consent determines the amount of information released.		
	E&T where detained	Packet for court filing including DOB, Diagnosis, clinical info and outpatient tx, SUD hx, next of kin, relevant history of preceding information. Authority is Chapter 70.02 RCW.		
	Next of kin	71.05.400 requires to send notice of E&T to which person is detained. Other info relevant to referral may be disclosed.		
	Parent or guardian of a minor	Same notice as next of kin, also copy of petition and Notice of Detention/ Statement of rights. Authority is 70.02 RCW. Discuss "mental and physical condition" and prognosis.		
	Public defenders (the attorney is assigned to the client for civil commitment proceedings)	Fact sheet – demographics & clinical info, enrollment info, declarations, notice of rights, notice of detention, notice to family custody authorization. Authority is 70.02. Treat attorney as the personal representative of client. No consent required and no accounting. Only		

	MH Data disclosed TO Agency	**Specific MH Information Disclosed[1]**	**SUD Data Disclosed TO Agency**	**Specific SUD Information Disclosed**
		need to document that this is the correct attorney if a private attorney, or to document that it is the correct court ordered attorney.		
	Jails (jail MH unit in KCCF, others in smaller jails), police, SPD Crisis Intervention team	For the purpose of treatment or addressing a safety risk, current provider or other information as necessary for the purpose.		
	DOC community corrections officers	With an authorization, the information authorized. CCS can call CCO in doing an evaluation to collect information without an authorization. However, CCS needs an authorization in order to give information to the CCO (e.g., CCS cannot tell CCO that client is in the hospital without an authorization).		
	Prosecutor (county employee)	No consent required and no accounting. Purpose is civil commitment.		
	State Hospital forensics unit psychologist or other psychologist under a criminal justice court order	Competency evaluation on a criminal justice court order 10.77 or elsewhere. Unless a court order allows it, must get a consent from the client.		
	Local Police who brought client to ER/PES after checkup complete	No PHI released – just the fact that the person is no longer being cared for by the MHP		
	Local hospitals	For the purpose of treatment, enrollment information and if person is on a court order for outpatient care		
	WA DOH. Child Death Review teams consist of health department personnel, CPS, Domestic Violence Advocacy and Injury Prevention (Injury Prevention person is a public health employee), and police.	For health care oversight per 70.02 RCW, Child death review (CDR). Any information required for the review.		

	MH Data disclosed TO Agency	**Specific MH Information Disclosed[1]**	**SUD Data Disclosed TO Agency**	**Specific SUD Information Disclosed**
Cross Systems Coordinator	Other agencies such as DCFS MH Providers	Purpose is our oversight of providers. Determining if service is being provided to specific clients of DCFS (who are all in the legal custody of DCFS). We determine that the client is in our system and with the particular provider and what services they are getting and give that information to DCFS. For further investigations, this gets passed on to client services if necessary. Authority is that DCFS can act as the personal representative of the client as they are in legal custody.		
	DDD or another state ancillary system	Purpose is coordination of care for shared clients. Information shared is enrollment and provider. Also may state what services have been given.		
Designated Care Authorizer Clinical Specialist and Care Manager	Department of Home and Community Staff City of Seattle Aging and Disability Services	Status of enrollment May include re-release to KCMHP provider, this may include SUD information in the packet. Share information with Department of Home and Community Services for Medicaid Personal Care (MHP) program payment eligibility.		
Designated Care Authorizer for SMIO	Department of Correction Staff To Provider (With consent using DOC ROI form)	Enrollment Status Clinical Information for care planning. Would also re-release information (including the future address of the client) receive from the Department of Correction to KCMHP provider, this may include SUD information in the packet. Provide the Department of Correction with information about where client was referred.		
Designated Care Manager for CIAP project	DOC Staff	Participation in clinical staffing. Receives packet from DOC. Purpose is treatment coordination. Does not re-release to provider (SMH). No information is disclosed. (Provider also receives packet from DOC).		

	MH Data disclosed TO Agency	**Specific MH Information Disclosed[1]**	**SUD Data Disclosed TO Agency**	**Specific SUD Information Disclosed**
Emergency Services Patrol	None	None	Sobering, HMC ER, detox, police, ambulance, fire department, REACH Case Managers	Name, location picked up, general condition when picked up including signs of recent drinking. Purpose is treatment and referral.
FACT Program Manager	Sound Mental Health	Referral information	Sound Mental Health	Referral information
Financial Administrative Support	Merino Translation Services	Fax list of names, date of service, and amount paid for authorization and denial information.		
	Residential invoices	Invoices include client name for reconciliation.		
Financial staff/SUD CFO	None	None	None (grouped unidentified data only)	None
Financial Staff for MH CFO	DSHS, AG criminal investigations, to report a crime	Persons performing financial audits for DSHS and other funders may see receipts that have client names on them. Billings from Aging & Adult Services (A&AS) for Medicaid Personal Care include client names to verify eligibility for payment. Authorization & denial information including client name is returned to A&AS with payment notification.	DSHS, AG criminal investigations, to report a crime	Persons performing financial audits for DSHS and other funders may see receipts that have client names on them.
	CFIC Auditors	CFIC auditor sees receipts and client records that have client names on them.		
	DCFS	Invoice packet includes client name for residential beds and diversion beds. DCFS Flex funds receipts for expenditures reimbursement contains client names, diagnosis, treatment plan, authorization amounts, actual expenditures on behalf of the client.		
	SAMHSA (CFIC)	CFIC study government financial audits access client names.		
	Sound Mental Health	KCID and Service data for what we pay for the CIAP program.		

	MH Data disclosed TO Agency	**Specific MH Information Disclosed[1]**	**SUD Data Disclosed TO Agency**	**Specific SUD Information Disclosed**
	Sound Mental Health, Valley Cities Counseling and Consultation, Navos, Seattle Children's Home, Transitional Resources	Fax back general information but if there is a discrepancy, fax KCID and amount denied and reason.		
Housing Coordinator	None	None	None	None
Information Services	Outpatient providers, PES MH	Authority is treatment coordination and quality assurance. Information in ECLS/CLS.	None	None
	Crisis Clinic, WSPH	Authority is treatment coordination and quality assurance. Information in ECLS/CLS and Inpatient.		
	DSHS	Contractually required data elements. Authority is Health Care Oversight.		
Integrated Database Project Specialist	None without ROI		None without ROI	
Interns/Volunteers	None		None	
MacArthur and Casey Family Program funded positions	None		None	
Management Team	To DSHS CMS	For health care oversight (including but not limited to fair hearing, grievances, appeals), any information necessary for the contractually required and/or legally required purposes.	DASAS DSHS	For health care oversight (including but not limited to fair hearing, grievances), any information necessary for the contractually required and/or legally required purposes.
	To MHP providers	For treatment, payment, and health care operations, any information necessary for the contractually required purposes.	CSO	Access information. CSO may have eligibility questions or complaints. Authority is health care operations.
Medical Directors	Outpatient providers, hospitals, and individual clients	Hospital appeals, 3B appeals, audits, complaints and grievances, EO Reviews	CD Providers	EO Reviews

	MH Data disclosed TO Agency	**Specific MH Information Disclosed[1]**	**SUD Data Disclosed TO Agency**	**Specific SUD Information Disclosed**
	DSHS	Special treatment planning about an individual client.		
	Consultations with other mental health professionals	Treatment related discussion on individual clients.		
	Schools	No PHI released without ROI		
MH Contracts	PES Manager and HMC	Working on challenging clients. Enrollment information. No client information released now except with ROI or research committee approval.	None	None
	State DSHS	Contract oversight, PALS, etc. Plan and follow-up for high utilizers. Purpose and authority is state oversight authority.		
	SPD/CIT	No releases of PHI without ROI.		
MH Contract Specialists	Contracted providers	Any information needed to monitor a contract. Authority is Health Care Oversight.	None	None
	WA State DSHS	FIRST client offender community transition report – status – enrollment, intensive service treatment plan. Authority is Health Care Oversight.		
	DOC	FIRST status information. ROI required.		
MIDD Project Manager	None		None	
PACT Program Manager	DESC, Navos, Transitional Resources, Valley Cities	Referral information	None	
PES MH/SUD staff	Detox	For the purpose of treatment, current risks, enrollment information, and any additional information they may need to provide treatment while the person is in a mental health detox bed.	HMC	For the purpose of assessment of the current crisis and for treatment planning, any information about substance abuse that client provides (such as history, symptomatology, treatment attempts).

	MH Data disclosed TO Agency	**Specific MH Information Disclosed[1]**	**SUD Data Disclosed TO Agency**	**Specific SUD Information Disclosed**
			Detox	For the purpose of treatment of the current crisis, any information about substance abuse that client provides (such as history, symptomatology, treatment attempts) and any additional information necessary.
			REACH Sobering	For the purpose of treatment or referral, any information to coordinate care of a current client or refer a new client.
QRT	None		None	
Recovery Specialist	None		None	
SPE	None except for studies approved by the Research and Evaluation committee	None except for studies approved by the Research and Evaluation committee	None except for studies approved by the Research and Evaluation committee	None except for studies approved by the Research and Evaluation committee
SPE/ Data Analyst	Providers	Data checking/QA feedback for payment/health care operations		
SPE/ Statistician	Researchers as approved by the Evaluation and Research Committee	Data approved by committee. Purpose is research		
	County Council State Legislature	No PHI. (Aggregate data for recovery ordinance)		
	Northwest Research Associates	FIRST evaluation data. Purpose is program evaluation required by state DSHS. (Health Oversight)		
	WA DSHS or their designee	Oversight data. Potentially any data.		

	MH Data disclosed TO Agency	**Specific MH Information Disclosed[1]**	**SUD Data Disclosed TO Agency**	**Specific SUD Information Disclosed**
Utilization Management function/ Work with WSH, MH Liaison, provider and DSHS to place challenging clients in our system	WSH CPC Liaisons WA State DSHS staff acting for the AG or Attorney General's office	Purpose is treatment coordination. Information shared includes enrollment status, the reason for hospitalization including patient's behavior both as an inpatient and outpatient, service history, outpatient history and substance abuse history. Authority is health care operations and/or health care oversight.	None	None
	DSHS Staff, oversight, non-health professionals	Oversight of placement of challenging clients. Purpose is state authority for oversight of MH program		

*Actual access and use is further restricted to protected health information that each staff person requires for the performance of his/her assigned tasks as defined and approved by his/her supervisor.

Redisclosure of Enrollment Information without Client Consent

When a person who is authorized to access client information in ECLS is asked by another about the enrollment status of a client, the person may release information without client consent in some circumstances. **The following information is used to determine if the disclosure is allowed.**

1. The requestor is one of the following:

- A licensed Mental Health Professional;
- A physician, physician's assistant, osteopathic physician, osteopathic physician's assistant, nurse (LPN, RN, or ARNP), or naturopathic physician;
- An administrative or support staff person designated by one of the above health care professionals to obtain medical information;
- Designated Mental Health Professionals inside or outside of King RSN; OR
- Emergency medical personnel currently treating the consumer.

AND

The information is being requested in order to arrange or provide mental health services to the consumer. Anyone requesting CLS/ECLS information must explain the circumstances so the person accessing ECLS is satisfied that the inquirer is designated personnel attempting to arrange services for the consumer and the information is needed in order to do so.

2. The requestor is a health care professional working directly with the consumer in a criminal justice facility

AND

The information is necessary for treatment of the consumer or to ensure the safety of the consumer or others in the facility.

3. The requestor is a law enforcement officer serving in a professional capacity at an appropriate law enforcement agency

AND

The information is necessary in one of the following circumstances:

- for the purpose of averting a serious threat to public health or safety during a crisis event or emergent situation; OR
- for the purpose of investigating reports of child or vulnerable adult abuse;

4. The requestor is attempting to assist a client who is the victim of a disaster

AND

- If the client is present, he/she is given an opportunity to object, OR
- If the client is not present or is incapacitated, the person with access to ECLS determines that the disclosure is in the best interest of the client or the disclosure is necessary to allow an authorized disaster relief entity to perform its function.

5. Once one of the above criteria have been met, the person with access to ECLS may provide information limited to whether or not the consumer is <u>currently</u> enrolled and with whom (name of agency, case manager name and phone number). (If the requestor is a health care professional from a hospital emergency department or psychiatric inpatient unit and information is needed to determine the need for admission, the inpatient treatment plan, or the follow-up or discharge plan, Crisis Clinic staff may provide any information pertinent to the purpose regarding either a current or past consumer.)

6. Requestors seeking further information about a particular consumer can be directed to call the provider agency with whom the consumer is currently enrolled.

7. Requestors or entities who do not represent designated personnel (listed above) or designated personnel requesting other information may be directed to call King County Mental Health Plan, Client Services, at 1-800-790-8049.

REQUEST FOR CLIENT INFORMATION without AUTHORIZATION
King County Mental Health, Chemical Abuse and Dependency Services Division
The Chinook Building
401 Fifth Avenue, Suite 400
Seattle, WA 98104

Client Name: _____
Previous Name: _____
Date of Birth: _____
Social Security #: _____
KCID: _____
Note: If information is requested on a group of individuals, use the space above to describe in detail the group.

I am requesting the following information.

Information: _____
_____
_____
_____
_____
_____

Purpose: _____
_____
_____
_____
_____
_____

This request is allowed by: (Cite MHCADSD P&P 5.6 or 5.11 or state/federal law/regulation. Be aware that a law/regulation allowing a disclosure may be overridden by a more stringent privacy law/regulation. If possible, list all relevant citations.)

_____
_____
_____

I agree that, if provided with the above information, the information will be used for no other purpose.

_____ _____
Signature of requester Date

Organization Phone

FOR INTERNAL USE ONLY:

Date Received:_____

Request has been ☐ Accepted ☐ Denied

If denied, check reason(s) for denial:
☐ The information is not in MHCADSD records.
☐ Client authorization is required.

Comments: _____

_____

Staff person processing request: _____

Date: _____

Form for Invalid Authorizations

Your consent or authorization form is invalid because of one or more of the following problems:

- 1. We are unable to identify the individual listed due to a lack of specific identifying information. In general, we need the following identifiers: Social Security Number, date of birth, and other names the person might have used when receiving care. Also, it would help locate records if we knew the approximate dates and location (site) of service.

- 2. The attached consent or authorization is not valid according to Federal and State Law[1]. In particular, the consent or authorization:
  - Is lacking the signature of the client (or if allowed or required, the parent, guardian, or other legal personal representative),
  - The signature shall be verified to confirm the requestor's identity. Guidelines for verification are:
  - Notarized signature on the authorization,
  - Client hand-delivers the authorization and presents a picture identification card confirming his/her identity,
  - The signature on the consent or authorization can be matched to a client signature on file, or
  - The consent or authorization is accompanied by a photocopy of the requestor's picture ID.

- 3. Does not identify the information (how much and what kind) to be disclosed in a specific and meaningful fashion. Information in our system relates to mental health and chemical dependency. A request for any of this information shall specify if the request is for mental health information, chemical dependency information or both.

- 4. Does not identify the purpose of the use or disclosure.

- 5. Does not identify the name, address and affiliation of the person who shall use the information or to whom the information is to be disclosed

- 6. Does not identify us as to the organization who is using or disclosing the information

- 7. Lacks an expiration date, except as allowed by 42 Code of Federal Regulations Part 2

- 8. Lacks a statement on revocability

In addition, an authorization for other than treatment, payment or health care operations requires the following items:

- 9. A statement on how to revoke and exceptions to right to revoke

- 10. A statement that information used or disclosed may be subject to redisclosure by the recipient and no longer be protected

[1] 45 Code of Federal Regulations (CFR) 164.508(b) and (c), 42 CFR 2.31, RCW 70.02.030

- ❑ 11. A statement about the ability or inability to condition, treatment, payment, enrollment or eligibility for benefits on the authorization.

- ❑ For children, specific additional requirements are:

  - ❑ For children under 13, a parent or guardian shall sign all authorizations for release of information.
  - ❑ For children age 13 and over, the person who shall authorize is determined by the type of treatment described in the records.
  - ❑ Inpatient chemical dependency (CD) treatment records may be released only with the authorization of the child and a parent (or guardian).
  - ❑ Inpatient mental health (MH) treatment records may be released only with the authorization of the child.
  - ❑ Outpatient CD or MH treatment records may be released only with the authorization of the child.

- ❑ Other: _____

_____

Signed by: _____ Date: _____

REQUEST TO COMMUNICATE BY ALTERNATE MEANS OR AT AN ALTERNATE LOCATION

King County Mental Health, Chemical Abuse and Dependency Services Division
The Chinook Building
401 Fifth Avenue, Suite 400
Seattle, WA 98104

Client Name: _____
Previous Name: _____
Date of Birth: _____
Social Security #: _____
KCID (If known):

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), you have the right to request we communicate with you by alternate means or at an alternate location, ***if you clearly state that the disclosure of all or part of the requested information could endanger you.***

Please be specific in the information regarding the location or means of communication that you prefer.

Information to be communicated:

Preferred Means of Communication: _____
Mail:
Fax:
Other: Please specify:

Alternate location for Communications:

Telephone number, if you wish to be contacted by telephone:

Date of Request:
Your request will be reviewed by the MHCADSD Privacy Officer for approval or denial.
If your request is denied, you will be notified.

I hereby clearly state that the disclosure of the information requested could clearly endanger me.

_____ _____
Signature of person or legal representative Date
Signature verified by: (driver's license, notarized, case manager signature, other)

(Completed form may be given to site HIPAA officer or mailed to the HIPAA Privacy Officer at the above address. Verification of the identity of the person signing this form will be required.)

FOR INTERNAL USE ONLY:

Identity of client verified by: _____

If signed by a legal representative, authority verified by: _____

Date Received:_____ Request has been ☐ Accepted ☐ Denied

Comments (Basis of denial) :
_____
_____
__
_____
__
_____
__
_____
__
_____
_____
_____
_____
_____

Client notified in writing on this date:
_____

Staff person processing this
request:_____

Log of Disclosures without Client Consent or Authorization Required for an Accounting

King County Mental Health, Chemical Abuse and Dependency Services Division

CLIENT NAME:_____ CLIENT DOB:_____
KCID:_____

The following disclosures should be logged on this form.

1. To a public health authority for the purpose of preventing or controlling disease, injury, or disability,
2. To a public authority authorized by law to receive reports of child or vulnerable adult abuse or neglect,
3. To the Food and Drug Administration,
4. To a health oversight agency (DASA, DSHS, CMS, HHS),
5. To an individual or organization in response to a court order or other legal process,
6. To law enforcement,
7. To the target of a threat,
8. To the federal government,
9. To researchers,
10. To a coroner, medical examiner, or funeral director,
11. Any disclosure required by law that is not on the above list,
12. Any disclosure, if known, made by a whistleblower acting in good faith,
13. Any disclosure not permitted by law.

Not all disclosures in these areas will be included in an accounting.

Date of disclosure:

MHCADSD staffperson making the disclosure:

Recipient of the PHI (name, organization, phone/address/fax):

Means of disclosure (phone, mail, e-mail, fax, etc):
Brief description of the PHI disclosed:

Purpose of the disclosure:

This disclosure without consent is allowed according to (cite law or P&P section):

Request to Revoke Consents (or Authorizations) for the Release of Information
King County Mental Health, Chemical Abuse and Dependency Services Division
The Chinook Building,
401 Fifth Avenue, Suite 400
Seattle, WA 98104

I, _____, request to revoke the consent/authorization for release of my protected health information that was signed on [approximate date]_____ for services provided by the following program (check all that apply):

- ☐ Psychiatric Emergency Services (PES) (MHCADSD staff at Harborview Emergency Room)
- ☐ Crisis and Commitment Services
- ☐ The Chinook Building MHCADSD main office
- ☐ Other (specify):_____

All consents for the release of protected health information expire within 90 days or less. This form should be returned to the above address or the location where you signed the consent/authorization.

A revocation will not affect information already released prior to the receipt of the revocation.

Revocation requests must be made in writing to the Privacy Officer at the above address. We will forward them to the appropriate location for processing. Additional revocation request forms are available on request.

Signature:_____ Date:_____

In response to your request of [date :_____] to revoke the previous consents signed on [date}_____for disclosure of information,

- ☐ We have located your consent/authorization for release of protected health information and have revoked this consent. This revocation does not affect any information that may have already been released.
- ☐ We have checked our files and have not found any authorizations or consents for release of information by you.

If you believe you have signed an authorization to release your protected health information, you might check with your mental health provider to see if they have one on file.
If you have any questions, call the Privacy Officer at _____.

This request was processed on [date]:_____
by [staff member]:_____ Title: _____

REQUEST TO AMEND OR CORRECT PROTECTED HEALTH INFORMATION
King County Mental Health, Chemical Abuse and Dependency Services Division
The Chinook Building,
401 Fifth Avenue, Suite 400
Seattle, WA 98104

Client Name: _____
Previous Name: _____
Date of Birth: _____
Social Security #: _____

I would like to amend part of my protected health information in your records.

Information to be amended: _____
_____
_____

If known, where is this information located in your record? _____
_____
_____

Please explain how the information is incorrect or incomplete. What should the entry say to be more accurate or complete?

_____
_____
_____

If we agree to make this requested change, would you like this amendment sent to anyone to whom we may have disclosed this information in the past? If so, please provide a written legal authorization to do so. (Authorization forms available on request)

_____ _____
Signature of client or legal representative Date

(Completed form may be given to site HIPAA officer or mailed to the HIPAA Privacy Officer at the above address. Verification of the identity of the person signing this form will be required.)

FOR INTERNAL USE ONLY:

Identity of client verified by: _____

If signed by a legal representative, authority verified by: _____

Date Received:_____

Amendment has been ☐ Accepted ☐ Denied Date: _____

If denied, check reason(s) for denial:

- ☐ MHCADSD was not the originator of this information and the originator is available to directly act on a request to amend.
- ☐ The information is not in MHCADSD records.
- ☐ The information is accurate and complete.
- ☐ The information was compiled for use in a legal proceeding.

_____	_____
Name of licensed MHP (print)	Title
_____	_____
Signature of licensed MHP	Date

Client notified of decision on this date: _____
(If denied, denial must include statement on client's right file a disagreement, client's right to note amendment request and denial on future MHCADSD disclosures, and client's right to complain to the secretary.)

Staff person processing request: _____

REQUEST TO RESTRICT ACCESS, USE, or DISCLOSURE OF PROTECTED HEALTH INFORMATION

King County Mental Health, Chemical Abuse and Dependency Services Division
The Chinook Building
401 Fifth Avenue, Suite 400
Seattle, WA 98104

Client Name: _____
Previous Name: _____
Date of Birth: _____
Social Security #: _____
KCID (If known): _____

Information to be restricted: _____

If known, where is this information located in your record? _____

How should this information be restricted? _____

Please explain why the entry should be restricted: _____

_____ _____
Signature of person or legal representative Date

(Completed form may be given to site HIPAA officer or mailed to the HIPAA Privacy Officer at the above address. Verification of the identity of the person signing this form will be required.)

FOR INTERNAL USE ONLY:

Identity of client verified by: _____

If signed by a legal representative, authority verified by: _____

Date Received:_____ Restriction has been ☐ Accepted ☐ Denied

Comments:_____
_____
_____
_____
_____
_____
_____
_____
_____

Client notified in writing on this date: _____

Staff person processing this request:_____

REQUEST FOR AN ACCOUNTING OF DISCLOSURES
King County Mental Health, Chemical Abuse and Dependency Services Division
The Chinook Building,
401 Fifth Avenue, Suite 400
Seattle, WA 98104

Client Name: _____
Previous Name: _____
Date of Birth: _____
Social Security #: _____

I would like an accounting of disclosures for the following time frame. I understand that the maximum time frame that can be requested is six years prior to the present date.

From: _____ To: _____

Address to which the accounting should be sent: _____
_____
_____
_____

I understand that the accounting will not contain disclosures that were made to carry out treatment, payment, or healthcare operations; disclosures to myself; disclosures to which I consented; and certain other disclosures that may be omitted according to law, as defined in the MHCADSD Policies and Procedures.

Fee (circle the correct fee for this request and enclose with request):
First request in a 12-month period: Free
Subsequent requests: _____

I understand that the accounting will be provided to me within 60 days unless I am notified in writing that an extension of up to 30 days is needed.

_____ _____
Signature of client or legal representative Date

(Completed form may be given to site HIPAA officer or mailed to the HIPAA Privacy Officer at the above address. Verification of the identity of the person signing this form will be required.)

FOR INTERNAL USE ONLY

Identity of client verified by: _____

If signed by a legal representative, authority verified by: _____

Date received: _____

Date Sent: (must be within 60 days, if no extension requested) _____

Extension Requested: ____ No ____ Yes (give reason): _____

Client notified in writing on this date: _____

Staff person processing request:_____

OATH OF CONFIDENTIALITY

King County Mental Health, Chemical Abuse and Dependency Services Division

I, _____, agree not to divulge, publish or otherwise
NAME OF PERSON TAKING OATH
make known to unauthorized persons, any information obtained through the King County Mental Health, Chemical Abuse and Dependency Services Division or any of its service sites or contractors regarding persons who have received services or were referred for services, such that the person who receives such services is identifiable. (42 Code of Federal Regulations [CFR] Part 2, 45 CFR Parts 160 and 164, Chapters 70.96A, 71.05, 71.24, and 71.34 Revised Code of Washington [RCW], Chapter 388-877 Washington Administrative Code).

I understand that my obligations to protect client confidentiality continue despite any termination of employment or change in job responsibilities.

I have read and agree to comply with the King County Mental Health, Chemical Abuse and Dependency Services Division Policies and Procedures on Protection of Confidential Client Information.

I recognize that unauthorized disclosure of confidential information may subject me to civil liability or criminal proceedings under the provisions of state law (RCW 70.02.170, RCW 71.05.440) and/or federal law (42 CFR Part 2 and 45 CFR Parts 160 and 164).

I further recognize that a request for or receipt of confidential information under pretense may subject me to criminal liability, which is punishable as a gross misdemeanor.

SIGNATURE OF PERSON TAKING OATH	DATE
SIGNATURE OF WITNESS	
SIGNATURE OF SUPERVISOR	TELEPHONE
SIGNATURE OF SITE SUPERVISOR	TELEPHONE

Disclosure of the minimum necessary electronic MH PHI without client authorization or consent*

Contracted Agency or Program	Clients	Applications
Crisis Clinic	All	ECLS, Inpatient, Masterperson, SQL
HMC PES staff	All	PES, ECLS, SQL
WSPH E&T staff	All	ECLS, Inpatient, SQL
Other staff at provider agencies	Current and past clients only, except current enrollment information will be available on all clients and, for staff providing crisis, engagement, screening, or intake services, information on all clients available by "click through"	CLS/ECLS, Masterperson, SQL
Jail PES	For those clients currently in jail	ECLS
ITA Court Personnel (Prosecuting Attorneys, Defense Attorneys, Court Commissioner, Supervising Judge, ITA Court Clerk, Hospital Court Evaluators, Hospital ITA Coordinators)	For those clients scheduled for ITA court	LOLA (ITA Court Schedule Only)

*Actual disclosure is further restricted in that a completed Privacy Committee application is also required

Note 1: Each agency will designate who should have access to Master Person and SQL.

Note 2: There will be a "click through" button to allow access to additional information on clients that are not previously or currently enrolled with that provider. By clicking through, the user will be indicating that the information is required for:

1) The identification, screening, and/or intake of a person who has been referred or is requesting services,
2) The provision of crisis or engagement services to the client one is looking up, or
3) The provision of liaison services (by contracted liaisons only) to the client one is looking up.

Use of this option will be tracked.

King County Mental Health, Chemical Dependency and Abuse Services Division
Information Systems Electronic Access Request (EAR) Application and User Agreement - PROVIDERS

☐ First Time Application ☐ Renewal ☐ Renewal with Change ☐ Change Application ☐ Termination of Access Request

Name: _____ Check One: ☐ Chemical Dependency Staff ☐ Mental Health Staff ☐ Neither

Employer: _____ Job Function: _____ User Name: _____

Site: _____ Agency ID: _____ Phone: _____ E-mail address: _____

As a condition of access, I commit and agree to be bound by the following:

- I understand that information contained in the MHCADSD information systems is owned and belongs to King County MHCADSD. I agree that at any time, MHCADSD may audit, investigate, monitor, access, and disclose information about my use of MHCADSD information systems.
- I will access, use, and disclose MHCADSD information only in accordance with the terms of this Agreement and consistent with applicable statutes, regulations, and policies.
- I am authorized to access, use and disclose only the "minimum necessary" MHCADSD information required to perform my job duties.
- I will disclose MHCADSD information only to individuals who have legal authority to access the information.
- I will not use my MHCADSD access to look up or view information about family members, friends, the relatives of friends or other employees, or any persons who are not directly related to my assigned job duties.
- I will protect the confidentiality and security of all MHCADSD information I am authorized to access, use and/or disclose by strictly adhering to the terms of this Agreement.
- I will access MHCADSD information only on secure workstations in non-public areas. I will use only my User ID and password to access MHCADSD information, and I will protect my password from disclosure and not allow anyone to access MHCADSD information with my User ID and password.
- I will immediately inform appropriate staff (as determined by policy) of any actual or potential security breaches involving MHCADSD information, or of any access to or use of MHCADSD information by unauthorized users.
- I understand that information about violations of this Agreement and/or breaches of confidentiality may be forwarded to appropriate authorities for possible civil and/or criminal remedies.
- I understand that MHCADSD may limit my access to those clients for whom it is determined that I have a legitimate reason to view.
- I understand that the MHCADSD EAR Form and User Agreement will be reviewed and signed by me and my site supervisor annually. _____ (Initials)

General Applications

☐ **Crisis Clinic Hospital Auth.** ☐ **Crisis Clinic Support Staff** ☐ **Crisis Clinic Care Coord.**	☐ **HMC PES**	☐ **HMC / Children's Inpatient Psych Unit, WSPH (NAVOS) Inpatient Unit**	☐ **WSPH (NAVOS) E&T**	☐ **DA(JD)**	☐ **Jail PES (PH-SKC)**	☐ **Staff at CD Provider Agencies**	☐ **Other Staff at Provider Agencies**
☐ ECLS ☐ Inpatient ☐ IS Utility (KCID Link) ☐ Master Person (Update) ☐ SQL	☐ CTU ☐ ECLS	☐ ECLS	☐ ECLS ☐ Inpatient (Invol) ☐ SQL	☐ Remote Access (Cit. Metaframe)	☐ ECLS (restricted)	☐ Sobering Center	☐ ART ☐ SQL ☐ MELS ☐ ECLS ☐ KCID Utility (Reconcile) ☐ Master Person (update) ☐ Secure File Server **Other**:

SIGNATURES		DATE
	Applicant	
	Applicant's Immediate Supervisor/ Witness	
	Site Supervisor	

DO NOT WRITE IN THIS BOX – FOR INTERNAL PROCESSING ONLY	
Ear Authorization Signature	
EAR Authorization Date	
Length of approval	12 months

Print Name of Site Supervisor:		Phone#:		Email Address:	

King County Mental Health, Chemical Dependency and Abuse Services Division
Information Systems Electronic Access Request (EAR) Application and User Agreement – MHCADSD Staff

☐ First Time Application ☐ Renewal ☐ Renewal with Change ☐ Change Application ☐ Termination of Access Request

Name: _____ Check One: ☐ Chemical Dependency Staff ☐ Mental Health Staff ☐ Neither

Employer: _____ Job Function: _____ User Name: _____

Site: _____ Agency ID: _____ Phone: _____ E-mail address: _____

As a condition of access, I commit and agree to be bound by the following:

- I understand that information contained in the MHCADSD information systems is owned and belongs to King County MHCADSD. I agree that at any time, MHCADSD may audit, investigate, monitor, access, and disclose information about my use of MHCADSD information systems.
- I will access, use, and disclose MHCADSD information only in accordance with the terms of this Agreement and consistent with applicable statutes, regulations, and policies (Section XIII, Attachment A).
- I am authorized to access, use and disclose only the "minimum necessary" MHCADSD information required to perform my job duties.
- I will disclose MHCADSD information only to individuals who have legal authority to access the information.
- I will not use my MHCADSD access to look up or view information about family members, friends, the relatives of friends or other employees, or any persons who are not directly related to my assigned job duties.
- I will protect the confidentiality and security of all MHCADSD information I am authorized to access, use and/or disclose by strictly adhering to the terms of this Agreement.
- I will access MHCADSD information only on secure workstations in non-public areas. I will use only my User ID and password to access MHCADSD information, and I will protect my password from disclosure and not allow anyone to access MHCADSD information with my User ID and password.
- I will immediately inform the Privacy Officer of any actual or potential security breaches involving MHCADSD information, or of any access to or use of MHCADSD information by unauthorized users.
- I understand that information about violations of this Agreement and/or breaches of confidentiality may be forwarded to appropriate authorities for possible civil and/or criminal remedies.
- I understand that MHCADSD may limit my access to those clients for whom it is determined that I have a legitimate reason to view.
- I understand that the MHCADSD EAR Form and User Agreement will be reviewed and signed by me and my site supervisor annually. _____ (Initials)

A= Add
D= Delete
S= Same
VA= View All
VP= View Partial
UA= Update All
UR= Update Restricted

MH Applications		General Applications		Miscellaneous		Data Tables (SQL)	
☐ CLS (Client Lookup System)		☐ ARMSlink		☐ CD-ITS Application		☐ CCS	
☐ CTU		☐ Contract Tracking (CDCT)		☐ Sobering Center		☐ Jail	
☐ ECLS (Extended Client Lookup System)		☐ CD Invoice Processing (CDIP)		☐ Medicaid Eligibility 270/271		☐ MHP	
☐ Inpatient		☐ Personnel		☐ Encrypted Email		☐ State Target Extract	
☐ LOLA (CCS only)		☐ Master Person		☐ Secure File Server			
☐ non-Medicaid Waitlist		☐ EO Database		☐ Remote Access (Citrix Metaframe)		☐ **LAN Only**	
☐ MELS Medicaid eligibility		☐ IS Utility (Link KCID, change Agency Case ID, etc…)		**Other:**			
☐ MAA Medicaid eligibility 270/271							

SIGNATURES		DATE
	Applicant	
	Applicant's Immediate Supervisor/ Witness	
	Site Supervisor	

DO NOT WRITE IN THIS BOX – FOR INTERNAL PROCESSING ONLY	
Ear Authorization Signature	
EAR Authorization Date	
Length of approval	12 months

Print Name of Site Supervisor: _____ Phone#: _____ Email Address: _____

MHCADSD Procedure for Making a CD Containing PHI

1. Discuss with the Privacy Officer whether the disclosure of data to be written to the CD is appropriate based on the privacy and confidentiality P&Ps and other laws and regulations.

2. Contact the designated MHCADSD LAN staff (or other assigned IS person) to encrypt the file(s).

3. Ask the designated MHCADSD LAN staff to prepare the label. Supply the title for the name of the file for the disk. Disk shall be labeled with the name of the file(s) and MHCADSD information as defined in the Confidentiality and Security P&P.

4. Prepare a log form (Section XIII, Attachment A, Appendix 10) to document the preparation and disclosure of the PHI. Give this to the Privacy Officer. If multiple clients shall be included on the data disk, only one log form should be prepared. The log should list the name of the file and the location of the file that specifies which clients are included. The privacy officer shall file the log form in the confidential client data files.

5. The transfer of the data CD from MHCADSD to the new owner shall be documented with a signature at the time of the transfer. Obtain a signature from the person who comes to pick up the CD or who receives the CD when it is brought in-person to the receiver. The signature should be affixed to a copy of the letter of delivery of the data, or to a statement saying what data is contained on the CD being delivered.

6. If the CD is to be sent by courier such as FedEx or the US Post Office, arrange for the delivery to be made with “signature required” as detailed in the Privacy Policy Section XIII Attachment A, Section 6.13.

DSHS POLICY 15-2; DSHS POLICY 2.2.1

OATH OF CONFIDENTIALITY

I, _____, agree not to divulge, publish, or otherwise make
(NAME OF PERSON TAKING OATH (PLEASE PRINT OR TYPE)
known to unauthorized persons* the information obtained by my access (in any form) to the Mental Health – Consumer Information System (MH-CIS). _____
APPLICANT INITIALS

I understand that this Oath is valid only if it carries my own signature and the required signatures of the authorized representatives qualified to grant access to the MH Intranet site. I further recognize that a request for or receipt of confidential information under pretense may subject me to criminal liability which is punishable as a gross misdemeanor (RCW 71.05.440). _____
APPLICANT INITIALS

I recognize that unauthorized release of confidential information may subject me to civil liability under the provisions of state law, and triple the damages of actual damages sustained. _____
APPLICANT INITIALS

*** An authorized person is an individual who can produce a valid, signed copy of this Oath showing that they have been approved for access to the MHD-CIS. Any individuals who are unable to do this are considered unauthorized.**

1.SIGNATURE OF PERSON TAKING OATH	2.DATE
3.EMAIL ADDRESS OF PERSON TAKING OATH	4.TELEPHONE NUMBER OF PERSON TAKING OATH

5.NAME OF WITNESS(PLEASE PRINT)	6.EMAIL ADDRESS OF WITNESS	7. DATE
8.SIGNATURE OF WITNESS	9.TELEPHONE NUMBER OF WITNESS	

SUBCONTRACTING AGENCY ONLY

10.SUBCONTRACTING AGENCY NAME	11. SUBCONTRACTING AGENCY ID NUMBER

12. AUTHORIZING REPRESENTATIVE (PLEASE PRINT)	13. SIGNATURE	14. TELEPHONE NUMBER

CONTRACTING USE ONLY

15. CONTRACTOR NAME (PLEASE PRINT)	16. CONTRACTOR ID	17.TELEPHONE NUMBER
18. CONTRACTOR EMAIL ADDRESS	19. SIGNATURE	20.. APPLICANTS LOGIN ID

21. ASSIGN AS A LOCAL ADMINISTRATO? IF YES, APPLICATION MUST COMPLETE THE "LOCAL ADMINISTRATOR AGREEMENT".

□ YES □ NO

DEPARTMENT OF SOCIAL AND HEALTH SERVICES (DSHS) USE ONLY

22. AUTHORIZING REPRESENTATIVE (PLEASE PRINT)	23.SIGNATURE	24. DATE

Please Note: This oath expires <u>one year</u> after access is authorized, a new oath will need to be submitted for continued access.

Entity Requirements

- You must complete an Oath of Confidentiality (read the instructions of the oath carefully). When completed fax the signed Oath of Confidentiality to: Your Local Administrator.

- Allow 2-3 working days for your local Administrator to create your account with appropriate access options and send you your User ID and password.

- Allow another 2-3 working days for your local Administrator to forward a copy of your signed Oath of Confidentiality to MHD Headquarters for review, filing, and account activation.

King County

Department of Community and Human Services
Mental Health, Chemical Abuse and Dependency Services Division
Business Associate Agreement

This Agreement is entered into between _____("Covered Entity") and _____("Business Associate").

The Business Associate acknowledges and agrees that Protected Health Information (PHI) can be used or shared only within the parameters of this document and the Department of Health and Human Services Privacy Regulations, Code of Federal Regulations, ("CFR"), Title 45, Sections 160 and 164, or as required by law.

CFR Title 45, Sections 160 and 164 are by way of reference, an integral part of this Agreement. Business Associate is charged with the knowledge of and agrees to abide by the terms and conditions of CFR Title 45, Sections 160 and 164.

The effective date of this Agreement is _____.

I. PURPOSE

The Covered Entity needs to make available and/or disclose to the Business Associate certain protected health information for management, administration, and legal responsibilities during the normal course of business between the parties (per *King County Contract No. ____).*

II. RESPONSIBILITIES OF BUSINESS ASSOCIATE

The Business Associate hereby agrees to do the following:

A. Use and Disclosure: Use and/or disclose PHI only as permitted or required by this Agreement, Health Insurance Portability and Accountability Act (HIPAA), and the Health Information Technology for Economic and Clinical Health Act (Division A, Title XIII of the American Recovery and Reinvestment Act of 2009, Pub. Law 111-5, 2009 HR 1) ("HITECH"). The Business Associate shall use and disclose PHI only if such use or disclosure, respectively, is in compliance with each applicable requirement of 45 CFR §164.504(e). The Business Associate is directly responsible for full compliance with the privacy provisions of HIPAA and HITECH that apply to the Business Associate to the same extent as the Covered Entity.

B. Security: Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI that it creates, receives, maintains, or transmits on behalf of the Covered Entity as required by CFR Title 45, Section 164, Subpart C. The Business Associate is directly responsible for compliance with the security provisions of HIPAA and HITECH to the same extent as the Covered Entity.

C. Improper Disclosures: Report all unauthorized or otherwise improper disclosures of PHI, or security incident, to the Covered Entity within two (2) days of the Business Associates knowledge of such event.

D. Notice of Breach: Within two (2) business days of the discovery of a breach as defined at 45 CFR §164.402 notify the Covered Entity of any breach of unsecured PHI. The notification shall include the

identification of each individual whose unsecured PHI has been, or is reasonably believed by the Business Associate to have been, accessed, acquired, or disclosed during such breach; a brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known; a description of the types of unsecured PHI that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved); any steps individuals should take to protect themselves from potential harm resulting from the breach; a brief description of what the Business Associate is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches; the contact procedures of the Business Associate for individuals to ask questions or learn additional information, which shall include a toll free number, an e-mail address, Web site, or postal address; and any other information required to be provided to the individual by the Covered Entity pursuant to 45 CFR §164.404, as amended. A breach shall be treated as discovered in accordance with the terms of 45 CFR §164.410. The information shall be updated promptly and provided to the Covered Entity as requested by the Covered Entity.

E. Mitigation: Mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement or the law.

F. Agents: Ensure that any agent, including all of its employees, representatives, and subcontractors, to whom it provides PHI received from, or created or received by Business Associate on behalf of Covered Entity agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.

G. Right of Access:

1. Make internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of Covered Entity available to the Covered Entity, or at the request of the Covered Entity to the Secretary of Department of Health and Human Services, within five (5) business days of written request by the Covered Entity or the Secretary, for the purpose of determining compliance with HIPAA, HITECH, and/or this Agreement.

2. Provide to Covered Entity, within five (5) business days of written request by Covered Entity information collected in accordance with this Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR §164.528, or to permit Covered Entity to respond to a request by an Individual for access to PHI in accordance with 45 CFR §164.524.

H. Documentation of Disclosures: Document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR §164.528. Should an individual make a request to Covered Entity for an accounting of disclosures of his or her PHI pursuant to 45 CFR § 164.528, Business Associate agrees to promptly provide an accounting, as specified under 42 U.S.C. § 17935(c) (1) and 45 CFR §164.528, of disclosures of PHI that have been made by the Business Associate acting on behalf of the Covered Entity. The accounting shall be provided by the Business Associate to the Covered Entity or to the individual, as directed by the Covered Entity.

I. Amendments: Make any amendments to PHI that the Covered Entity directs or agrees to pursuant to 45 CFR §164.526 at the request of Covered Entity, within five (5) business days of written request by Covered Entity.

J. Other: To the extent the Business Associate is to carry out one or more of the covered entity's obligations under Subpart E of 45 CFR 164, comply with the requirements of Subpart E that apply to the covered entity in the performance of such obligations.

III. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

A. Except as otherwise limited in this Agreement or by law, Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. The Business Associate shall limit its use and disclosure of, and requests for, PHI to the minimum necessary as determined in accordance with 42 U.S.C. § 17935(b)(1).

B. Except as otherwise limited in the Agreement or by law, Business Associate may use PHI to provide Data Aggregation services to Covered Entity as permitted by 45 CFR § 164.504.(e)(2)(i)(B).

IV. TERM AND TERMINATION

A. Term: This Agreement shall become effective on the Effective Date and shall continue in effect until all obligations of the parties have been met, unless terminated as provided herein or by mutual agreement of the parties

B. Termination for Cause: Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement if Business Associate does not cure the breach or end the violation within ten (10) business days of receipt of written notice by the Covered Entity, or immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and cure is not possible.

C. Other Termination: This Agreement may be terminated by Covered Entity upon thirty (30) days prior written notice to the other party, which notice shall specify the date of termination.

D. Effect of Termination: Except as provided in paragraph B. of this Section, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.

In the event that Business Associate determines that returning or destroying the PHI is not feasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further disclosures of such PHI to those purposes that make return or destruction infeasible, for so long as Business Associate maintains such PHI.

V. MISCELLANEOUS

A. Defense and Indemnification: Business Associate shall defend, indemnify and hold harmless Covered Entity from and against all claims, liabilities, judgments, fines, assessments, penalties, awards or other expenses, of any nature whatsoever, including without limitation attorneys fees, expert witness fees, and costs of investigation, litigation, or dispute resolution, relating to or arising out of any breach of this Agreement by Business Associate, its employees, officers, agents, or sub-contractors.

B. Reimbursement for Costs Incurred Due to Breach: Business Associate shall reimburse Covered Entity, without limitation, for all costs of investigation, dispute resolution, notification of individuals, the media, and the government, and expenses incurred in responding to any audits or other investigation relating to or arising out of a breach of unsecured PHI by the Business Associate.

C. Regulatory References: A reference in this Agreement to a Section in the Department of Health and Human Services Privacy Regulations, CFR, Title 45, Sections 160 and 164 means the Section as in effect or as amended, and for which compliance is required.

D. Amendment: The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Department of Health and Human Services Privacy Regulations, CFR, Title 45, Sections 160 and 164.

E. Notices: Whenever Covered Entity or Business Associate is required to give notice to the other party, notice shall be in writing, posted in the US Mail, and deemed delivered after three (3) business days.

F. Survival: The obligations of the Business Associate shall survive the termination of this Agreement.

G. Interpretation: Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with the Department of Health and Human Services Privacy Regulations, CFR, Title 45, Sections 160 and 164.

FOR: Business Associate	**FOR: Covered Entity**
_____	_____
Authorized Signature	Authorized Signature
_____	_____
Print Name	Print Name
_____	Department Director
Print Title	Print Title
_____	_____
Date	Date
Mailing Address	Mailing Address
_____	401 Fifth Avenue, Suite 500
_____	Seattle, WA 98104-2377
City, State, Zip + 4	City, State, Zip + 4

King County

MENTAL HEALTH, CHEMICAL ABUSE AND DEPENDENCY SERVICES DIVISION RESEARCH AND EVAULATION DATA SHARING AGREEMENT

I. SUBJECT

The following Data Sharing Agreement (Agreement) is entered into between the King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) and _____ (Data Recipient) on _____, and shall expire on: _____, or if no date is inserted, shall expire one year after the signature date.

II. DEFINITIONS

Confidential information means information that is exempt from disclosure to the public or other unauthorized persons under 45 CFR, or other federal or state laws. Confidential information includes, but is not limited to, personal information and/or individually identifiable health information.

Data means the information, whether initially provided by the Data Recipient and that is disclosed or exchanged by Data Provider as described by this Agreement. The information initially provided by the Data Recipient shall be considered to be owned by the Data Provider for as long as it is combined with information that originated with the Data Provider.

Data Provider means the entity that is disclosing their Data for use by the Data Recipient for completion of this Agreement. For this agreement the Data Provider is:
_____.

Data Recipient means the entity that is receiving the Data from the Data Provider for purposes of completion of this Agreement. For this agreement the Data Recipient is:
_____.

Individually Identifiable Health Information means health information, including demographic information, collected from an individual, that is created or received by a covered entity; and relates to the past, present or future physical or mental health or condition of an individual; or the past, present, or future payment for the provision of health care to an individual; and identifies the individual; or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Designated Staff means the Data Recipient's employee(s) whom the Data Recipient has authorized to access Data. Each Designated Staff shall complete and submit the Oath of Confidentiality (Attachment C) to: MHCADSD Privacy Officer, 401 Fifth Avenue, Ste 400, Seattle, WA 98104

Encrypt means to encipher or encode electronic data using software that generates a minimum key length of 128 bits.

Protected Health Information (PHI) means any individually identifiable health information that is transmitted by electronic media; maintained in electronic media; or transmitted or maintained in other form or medium.

III. PURPOSE

The purpose of this Data Sharing Agreement (Agreement) is for MHCADSD to provide Data that is individually identifiable health information to the Data Recipient as described in the attached application entitled "_____."

A copy of the MHCADSD Research and Evaluation Proposal Application, and if requested by the Data Provider, a copy of the research application to the IRB, are attached to, and made part of, this Agreement.

If the application requires IRB approval, a copy of the IRB determination is also attached to, and made part of, this Agreement. The IRB has determined that disclosure of individually identifiable health information shall be accomplished by:

☐ IRB Waiver of Informed Consent ☐ Participant's Informed Consent / Authorization

☐ Limited Data Set

IV. STATEMENT OF WORK

The Data Recipient shall provide the services and staff, and otherwise do all things necessary for or incidental to the performance of work, as set forth below:

A. Purpose

Activity for which the Data is needed: *(Insert summary of proposal from R&E Proposal application)*

How Data Recipient will use the Data: *(Insert summary of proposal from R&E Proposal application)*

B. Description of Data

MHCADSD shall develop and provide the Data Recipient an electronic Data file with the following:

- Inclusion criteria (filter variables)
- File format
- Data Elements *(provide detailed listing)*

The Data Recipient will notify the MHCADSD Contact if other identifiable data not specified in this Agreement are needed for the study. In the event that additional data are needed for the study, a revision to this Agreement may be required.

C. Source of Data

MHCADSD will provide Data from the King County Mental Health, Chemical Abuse and Dependency Services databases.

Time frame (s) for Data disclosure or exchange: *To be determined by each agreement*

D. Data Retention

Data Identifiers will be destroyed on __/__/__, or at the earliest opportunity consistent with the conduct of research, unless there is a health or research justification for retaining identifiers. In studies where participant authorization is obtained, use and retention of the Data must be consistent with the authorization form that the participant signed.

The Data Recipient will maintain, document and retain records of informed consent from each participant or the participant's legally authorized representative required by law and stipulated by the IRB unless the IRB determines that waiver of some or all of the elements of informed consent has been approved for this research.

E. Management of Data Identifiers

The Data Recipient will create a master identifier file which links names and direct identifiers with arbitrary study codes, protect this master file via a secure method, (i.e., password or permission-limited folder) known only to the Data Recipient's Designated Staff, and maintain all copies of the master file in a secure, locked location at all times when not in use.

The Data Recipient will remove names, and other data elements which could identify individuals, from records in the study data base, identify records in the database only with arbitrary study codes, and ensure that, without access to the master identifier file or MHCADSD information, all database records are unidentifiable.

Conditions under which, if any, that Data disclosed or exchanged can be linked to other data:

> MHCADSD information or Data shall not be linked with information or data from sources other than those identified in the MHCADSD Research and Evaluation Proposal application without the express written permission of the MHCADSD Contact.

F. Data Access Transfer Method

All data transfers will occur via an encrypted disc, or via the MHCADSD secure server file transfer protocol (FTP).

G. Requirements for Access

Access to Data shall be limited to Data Recipient's Designated Staff whose duties specifically require access to such Data in the performance of their assigned duties. Prior to making Data available to its Designated Staff, Data Recipient will notify all such persons of the MHCADSD Oath of Confidentiality, a sample of which is attached to this Agreement, as Attachment C. Each such notified person shall then sign a copy of this Oath in which they agree to adhere to the Oath of Confidentiality requirements. The Data Recipient will send the signed Oaths to:

King County MHCADSD Privacy Officer
401 Fifth Avenue, Suite 400
Seattle, WA 98104

H. Frequency of Exchange

The frequency for which data is to be disclosed to the Data Recipient is _____.

I. Security of Data

The Data Recipient shall exercise due care to protect Data from unauthorized physical and electronic access. Due care includes establishing and maintaining security policies, standards, and procedures which comply with the Data Security Requirements (Attachment A), Protection of Data.

The Data Recipient shall comply with Attachment A, Data Security Requirements with regard to Data Segregation and Data Disposition.

When the research has been completed or when no longer needed, whichever is earlier, the Data shall be returned to MHCADSD, or destroyed using one or more of the methods of destruction described in Attachment A, MHCADSD Data Security Requirements, 3) Data Disposition. Upon destruction or return of the data, the Data Recipient must complete Attachment B, Certification of Data Disposition and return to the MHCADSD Privacy Officer.

J. Confidentiality and Nondisclosure

The Data Recipient may use MHCADSD information or Data gained by reason of the Agreement only for the purposes of this Agreement.

The Data Recipient shall not disclose, publish, provide access to, or otherwise make known any individually identifiable information in MHCADSD Data or de-identified limited data set provided under this Agreement, except as provided by law.

The Data Recipient shall maintain the confidentiality of all individually identifiable information and Data gained by reason of this Agreement.

The Data Recipient shall not link the Data with individually identifiable information or Data from any other source nor re-disclose or duplicate the Data unless specifically authorized to do so in this Agreement or by the prior written consent of MHCADSD.

The Data Recipient shall not contact or attempt to contact any person identified in the information provided by MHCADSD without the express written permission of the MHCADSD Contact.

K. Data Security Compromise

The Data Recipient shall report to the MHCADSD Privacy Officer any security or confidentiality compromise or potential security or confidentiality compromise of shared Data within one (1) business day of discovery.

V. NOTICES

Whenever one party is required to give notice to the other party under this Agreement, it shall be deemed given if mailed by the United States Postal Service, registered or certified mail, return receipt requested, postage prepaid and addressed as follows:

In the case of notice to the Data Recipient, notice shall be sent to the point of contact submitted to MHCADSD on the Research and Evaluation Proposal Application;

In the case of notice to MHCADSD, notice shall be sent to:

King County MHCADSD Privacy Officer
401 Fifth Avenue, Suite 400
Seattle, WA 98104

Said notice shall become effective on the date delivered as evidenced by the return receipt or the data returned to sender for non-delivery other than for insufficient postage. Either party may at any time change its address for notification purposes by mailing a notice in accordance with this Section, stating the change and setting forth the new address, which shall be effective on the tenth (10^{th}) day following the effective date of such notice unless a later day is specified in the notice.

VI. MISCELLANEOUS

MHCADSD assumes no responsibility for the accuracy or integrity of data derived or created from the Data provided under this Agreement, or for the accuracy or integrity of the Data once the Data Recipient has altered or modified the Data, or linked the Data with other data files.

MHCADSD assumes no responsibility for the accuracy or validity of published or unpublished conclusions based in whole or in part on analyses of Data provided to the Data Recipient.

The Data Recipient will hold MHCADSD harmless from any damage or other liability which might be assessed against MHCADSD as a result of any information or Data received pursuant to this Agreement.

The Data Recipient agrees that MHCADSD shall have the right, at any time, to monitor, audit and review activities and methods in implementing this Agreement in order to assure compliance.

VII. SANCTIONS

Unauthorized disclosure or use of any Data provided under this Agreement may result in State and/or Federal civil and/or criminal penalties (RCW 42.48.050; CFR Part 45, Subpart D, 160.404, 408, and 418; CFR Part 2.32).

VIII. AMENDMENTS

Either party to this agreement may request changes to this Agreement, including amendments. Proposed changes that are mutually agreed upon will be incorporated by written amendment to this agreement.

The Data Recipient will seek an amendment when there is a substantial change in study design and methods, changes that may affect approved study purposes, and/or use of this information of thesis, dissertation, or other educational purposes that are not described in the Data Recipient's original proposal.

IX. TERMINATION

In the event the Data Recipient fails to comply with any terms of this Agreement, MHCADSD shall have the right take such action, as it deems appropriate, including termination of this Agreement. If the Agreement is terminated, the Data Recipient will return all information and Data provided by MHCADSD, including all materials derived from this information, or make such alternative disposition of provided and derived information as directed by MHCADSD. The exercise of remedies pursuant to this section shall be in additional to all sanctions provided by law, and to legal remedies available to parties injured by unauthorized disclosure.

Signed:

King County:	Data Recipient:
_____	_____
Authorized Signature	Authorized Signature
_____	_____
Print Name	Print Name
_____	_____
Print Title	Print Title
_____	_____
Date	Date
Mailing Address	Mailing Address
_____	_____
_____	_____
City, State, Zip + 4	City, State, Zip + 4

DATA SECURITY REQUIREMENTS

1. Protection of Data

The Business Associate will store data on one or more of the following media and protect the data as described:

a. **Hard disk drives**. Data stored on local workstation hard disks. Access to the data will be restricted to authorized users by requiring logon to the local workstation using a unique user ID and complex password or other authentication mechanisms which provide equal or greater security, such as biometrics or smart cards.

b. **Network server disks**. Data stored on hard disks mounted on network servers and made available through shared folders. Access to the data will be restricted to authorized users through the use of access control lists which will grant access only after the authorized user has authenticated to the network using a unique user ID and complex password or other authentication mechanisms which provide equal or greater security, such as biometrics or smart cards. Data on disks mounted to such servers must be located in an area which is accessible only to authorized personnel, with access controlled through use of a key, card key, combination lock, or comparable mechanism.

c. **Optical discs (CDs or DVDs) in local workstation optical disc drives**. Data provided by King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) on optical discs which will be used in local workstation optical disc drives and which will not be transported out of a secure area. When not in use for the contracted purpose, such discs must be locked in a drawer, cabinet or other container to which only authorized users have the key, combination or mechanism required to access the contents of the container. Workstations which access MHCADSD data on optical discs must be located in an area which is accessible only to authorized personnel, with access controlled through use of a key, card key, combination lock, or comparable mechanism.

d. **Optical discs (CDs or DVDs) in drives or jukeboxes attached to servers**. Data provided by MHCADSD on optical discs which will be attached to network servers and which will not be transported out of a secure area. Access to data on these discs will be restricted to authorized users through the use of access control lists which will grant access only after the authorized user has authenticated to the network using a unique user ID and complex password or other authentication mechanisms which provide equal or greater security, such as biometrics or smart cards. Data on discs attached to such servers must be located in an area which is accessible only to authorized personnel, with access controlled through use of a key, card key, combination lock, or comparable mechanism.

e. **Paper documents**. Any paper records must be protected by storing the records in a secure area which is only accessible to authorized personnel. When not in use, such records must be stored in a locked container, such as a file cabinet, locking drawer, or safe, to which only authorized persons have access.

f. **Data storage on portable devices or media.** MHCADSD data shall not be stored by the Business Associate on portable devices or media unless specifically authorized. If so authorized, the data shall be given the following protections:

- Encrypt the data with a key length of at least 128 bits
- Control access to devices with a unique user ID and password or stronger authentication method such as a physical token or biometrics.
- Manually lock devices whenever they are left unattended and set devices to lock automatically after a period of inactivity, if this feature is available. Maximum period of inactivity is 20 minutes.

Physically protect the portable device(s) and/or media by:

- Keeping them in locked storage when not in use.
- Using check-in/check-out procedures when they are shared, and
- Taking frequent inventories

1) When being transported outside of a secure area, portable devices and media with confidential MHCADSD data must be under the physical control of Business Associate's staff with authorization to access the data.

2) Portable devices include, but are not limited to; handhelds/PDAs, Ultramobile PCs, flash memory devices (e.g., USB flash drives, personal media players), portable hard disks, and laptop/notebook computers if those computers may be transported outside of a secure area.

3) Portable media includes, but is not limited to; optical media (e.g., CDs, DVDs), magnetic media (e.g., floppy disks, tape, Zip or Jaz disks), or flash media (e.g., CompactFlash, SD, MMC).

2. Data Segregation

MHCADSD data must be segregated or otherwise distinguishable from non-MHCADSD data. This is to ensure that when no longer needed by the Business Associate, all MHCADSD data can be identified for return or destruction. It also aids in determining whether MHCADSD data has or may have been compromised in the event of a security breach.

a. MHCADSD data will be kept on media (e.g., hard disk, optical disc, tape, etc.) which will contain no non-MHCADSD data; or,

b. MHCADSD data will be stored in a logical container on electronic media, such as a partition or folder dedicated to MHCADSD data; or,

c. MHCADSD data will be stored in a database which will contain no non-MHCADSD data; or,

d. MHCADSD data will be stored within a database and will be distinguishable from non-MHCADSD data by the value of a specific field or fields within database records; or

e. When stored as physical paper documents, MHCADSD data will be physically segregated from non-MHCADSD data in a drawer, folder, or other container.

When it is not feasible or practical to segregate MHCADSD data from non-MHCADSD data, then both the MHCADSD data and the non-MHCADSD data with which it is commingled must be protected as described in this exhibit.

3. Data Disposition

When the contracted work has been completed or when no longer needed, whichever is earlier, data shall be returned to MHCADSD or destroyed in accordance with the methods specified below. Media on which data may be stored and associated acceptable methods of destruction are as follows:

Data stored on:	**Will be destroyed by:**
Server or workstation hard disks	Using a "wipe" utility which will overwrite the data at least three (3) times using either random or single character data; or Degaussing sufficiently to ensure that the data cannot be reconstructed; or Physically destroying the disk.
Paper documents with sensitive or confidential data	Recycling through a contracted firm provided the contract with the recycler assures that the confidentiality of data will be protected.
Paper documents containing confidential information requiring special handling (e.g., protected health information)	On-site shredding, pulping, or incineration.
Optical discs (e.g., CDs or DVDs)	Incineration, shredding, or completely defacing the readable surface with a course abrasive.
Magnetic tape	Degaussing, incinerating or crosscut shredding.
Removable media (e.g., floppies, USB flash drives, portable hard disks, Zip or similar disks)	Using a "wipe" utility which will overwrite the data at least three (3) times using either random or single character data; or Physically destroying the disk; or Degaussing magnetic media sufficiently to ensure that the data cannot be reconstructed.

4. Notification of Compromise or Potential Compromise. The compromise or potential compromise of MHCADSD shared data must be reported to the MHCADSD Contact within one (1) business day of discovery.

5. Data shared with Sub-Contractors

If MHCADSD data provided under this contract is to be shared with sub-contractors, the agreement with the sub-contractors must include all of the data security provisions within this agreement and within any amendments, attachments, or exhibits within this agreement. If the Business Associate cannot protect the data as articulated within this agreement, then the contract with the sub-contractors must be submitted to the MHCADSD Contact specified for this agreement for review and approval.

CERTIFICATION OF DATA DISPOSITION

Date of Disposition: _____

___ All copies of any data sets related to Business Associate Agreement between _____ and King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) dated _____ have been wiped from data storage systems.

___ All materials and non-wiped computer media containing any data sets related Business Associate Agreement between _____and MHCADSD dated _____ have been destroyed.

___ All copies of any data sets related to Business Associate Agreement between _____ and MHCADSD dated _____ that have not been disposed of in a manner described above, have been returned to the MHCADSD Privacy Officer.

The Business Associate hereby certifies, by signature below that the data disposition requirements as provided in the data sharing agreement between _____ and MHCADSD dated ___, 201_), Attachment A., Section 3, Data Disposition have been fulfilled as indicated above.

Signature of Business Associate: _____ Date: _____

Return original to:

MHCADSD Privacy Officer
401 Fifth Avenue, Suite 400
Seattle, WA 98104

Retain a copy for your records.

OATH OF CONFIDENTIALITY – Research & Evaluation Data Sharing Agreement
King County Mental Health, Chemical Abuse and Dependency Services Division

I, _____, agree not to divulge, publish or otherwise
NAME OF PERSON TAKING OATH
make known to unauthorized persons, any information obtained through the King County Mental Health, Chemical Abuse and Dependency Services Division or any of its service sites or contractors regarding persons who have received services or were referred for services, such that the person who receives such services is identifiable. (42 Code of Federal Regulations [CFR] Part 2, 45 CFR Parts 160 and 164, Chapters 70.96A, 71.05, 71.24, and 71.34 Revised Code of Washington [RCW], Chapter 388-877 Washington Administrative Code).

I understand that my obligations to protect client confidentiality continue despite any termination of employment or change in job responsibilities.

I recognize that unauthorized disclosure of confidential information may subject me to civil liability or criminal proceedings under the provisions of state law (RCW 70.02.170, RCW 71.05.440) and/or federal law (42 CFR Part 2 and 45 CFR Parts 160 and 164).

I further recognize that a request for or receipt of confidential information under pretense may subject me to criminal liability, which is punishable as a gross misdemeanor.

SIGNATURE OF PERSON TAKING OATH	DATE
SIGNATURE OF WITNESS	

The above individual has been informed of the limitations, use or publishing of confidential information.

SIGNATURE OF SUPERVISOR	TELEPHONE
SIGNATURE OF SITE SUPERVISOR	TELEPHONE

King County

Data Use Agreement for Limited Data Set

This Data Use Agreement for Protection of a Limited Data Set (LDS) is entered into between the King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) and _____ (hereinafter "Data Recipient"), effective _____, and shall expire on: _____, or if no date is inserted, shall expire one year after the signature date.

DEFINITIONS:
"**Disclosure**" means the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

"**Use**" means the sharing, employment, application, utilization, examination, analysis, canonization, or commingling with other information.

"Limited Data Set" is protected health information that excludes the following direct identifiers of the individual or of relatives, employers, or household members of the individual: Names; Postal address information, other than town or city, State, and zip code; Telephone numbers; Fax numbers; Electronic mail addresses; Social security numbers; Medical record numbers; Health plan beneficiary numbers; Account numbers; Certificate/license numbers; Vehicle identifiers and serial numbers, including license plate numbers; Device identifiers and serial numbers; Web Universal Resource Locators (URLs); Internet Protocol (IP) address numbers; Biometric identifiers, including finger and voice prints; and Full face photographic images and any comparable images.

"Protected Health Information" means Individually Identifiable Health Information that is (i) transmitted by electronic media, (ii) maintained in any medium constituting electronic media, or (iii) transmitted or maintained in any other form or medium. "Protected Health Information" shall not include (i) education records covered by the Family Educational Right and Privacy Act, as amended, 20 U.S.C. §1232g(a)(4)(B)(iv).

"Individually Identifiable Health Information" means a subset of health information, including demographic information collected from an individual, and (i) is created or received by a health care provider, health plan, employer or health care clearinghouse and (ii) relates to the past, present or future physical or mental health or condition of an individual; and (a) identifies the individual, or (b) with respect to which there is a reasonable basis to believe that the information can be used to identify an Individual.

PURPOSE OF ACTIVITIES:
MHCADSD agrees to provide the Data Recipient with a Limited Data Set, which means that all direct client identifiers have been removed, except those identifiers which are allowed in a limited data set.

Data Recipient will only use or disclose the LDS information for the following limited purposes:
(Check all applicable boxes.)

- ❑ Research
- ❑ Public Health
- ❑ Health Care Operations

The identifiable elements that are allowed in a Limited Data Set, and that will be included in this data set are as follows:

Individually Identifiable Data Elements allowed in a limited data set	***Element(s) included in this set***
State, county, city, precinct and five digit zip code	
Admissions, discharge & service dates	
Birth date	
Date of death	
Age (including age 90 or over)	

OBLIGATIONS OF DATA RECIPIENT:

A. Use or Disclosure of LDS. Data Recipient shall not use or disclose the LDS received from MHCADSD in any manner is not specifically authorized by this Agreement or that would constitute a violation of federal law, specifically the Health Insurance Portability and Accountability Act of 1996 and any regulations enacted pursuant to its provisions ("HIPAA Standards") and Washington state law. Data Recipient shall ensure all directors, officers, employees, contractors, and agents use or disclose the LDS in accordance with the provisions of this agreement and federal and state law. Data Recipient must obtain specific authorization in the form of another written Data Use Agreement to use or disclose the information disclosed by MHCADSD for any purpose other than that specifically authorized herein.

B. Minimum Necessary. Data Recipient represents that the LDS contains the minimum necessary information to accomplish the purpose identified.

C. Safeguards Against Unauthorized Use or Disclosure of LDS. Data Recipient agrees to implement all safeguards appropriate to prevent the unauthorized use or disclosure of the LDS.

D. Reporting of Unauthorized Use or Disclosure of LDS. Data Recipient shall report in writing any unauthorized use or disclosure of the LDS not provided for in this Agreement within five (5) working days of becoming aware of an unauthorized use or disclosure. Data Recipient shall take immediate steps to stop the unauthorized disclosure and cure the breach of confidentiality. Written notification will be made to the following person:

King County MHCADSD Privacy Officer
400 Fifth Avenue, Suite 400
Seattle, WA 98104

E. Agreements with Third Parties. Data Recipient agrees to ensure that any agents, including any subcontractors, will be bound to the same restrictions and conditions that apply to Data Recipient**.**

F. Contact with Individuals. Data Recipient agrees not to try to identify the information contained in the LDS and not to contact the patients who are the subject of the LDS.

G. Sanctions. Unauthorized disclosure or use of any Data provided under this Agreement may result in State and/or Federal civil and/or criminal penalties (RCW 42.48.050; CFR Part 45, Subpart D, 160.404, 408, and 418; CFR Part 2.32).

H. Amendments. Either party to this agreement may request changes to this Agreement, including amendments. Proposed changes that are mutually agreed upon will be incorporated by written amendment to this agreement.

The Data Recipient will seek an amendment when there is a substantial change in study design and methods, changes that may affect approved study purposes, and/or use of this information of thesis, dissertation, or other educational purposes that are not described in the Data Recipient's original proposal.

I. Termination. In the event the Data Recipient fails to comply with any terms of this Agreement, MHCADSD shall have the right take such action, as it deems appropriate, including termination of this Agreement. If the Agreement is terminated, the Data Recipient will return all information and Data provided by MHCADSD, including all materials derived from this information, or make such alternative disposition of provided and derived information as directed by MHCADSD. The exercise of remedies pursuant to this section shall be in additional to all sanctions provided by law, and to legal remedies available to parties injured by unauthorized disclosure.

Signed:

King County:	Data Recipient:
_____	_____
Authorized Signature	Authorized Signature
_____	_____
Print Name	Print Name
_____	_____
Print Title	Print Title
_____	_____
Date	Date
Mailing Address	Mailing Address
_____	_____
_____	_____
City, State, Zip + 4	City, State, Zip + 4

Washington State Department of Social & Health Services

PRISM Registration

☐ New User
☐ Continuing User

Registration Information

EMPLOYEE'S NAME (FIRST, MIDDLE, LAST)	EMPLOYEE'S JOB TITLE	EMPLOYEE'S PHONE NUMBER
EMPLOYEE'S E-MAIL ADDRESS	NAME OF EMPLOYER	
IF DSHS / HCA EMPLOYEE, PROVIDE DIVISION OR OFFICE	IF DSHS / HCA BUSINESS ASSOCIATE, PROVIDE A CONTRACT NUMBER	
EMPLOYER'S STREET ADDRESS	CITY	STATE ZIP CODE

Regulatory Requirements and Penalties

State laws (e.g., RCW 74.04.060) and federal regulations (HIPAA Privacy Rule) prohibit the unauthorized access, use, or disclosure of confidential client information in PRISM. RCW 70.02.050, RCW 71.05.630, RCW 71.34.340, and 42 CFR 2, 42 CFR 431, 45 CFR 205, and the HIPAA Security Rule also apply to PRISM. Violation of RCW 74.04.060 is a gross misdemeanor. Violation of HIPAA Privacy and Security Rules can result in civil monetary penalties and criminal prosecution. Breaches of unsecured protected health information in PRISM are subject to requirements in 45 CFR, Part 164, Subpart D.

PRISM User Agreement

As a condition for my access to PRISM, I commit and agree to be bound by the following:

PRISM Ownership and Oversight

- I understand that information contained in PRISM is owned and belongs to DSHS and the Health Care Authority (HCA). I agree that at any time, DSHS or HCA may audit, investigate, monitor, access, and disclose information about my use of PRISM.

Authorization to Access, Use, and Disclose PRISM Information

- I will access, use, and disclose PRISM information only in accordance with the terms of this Agreement and consistent with applicable statutes, regulations, and policies.
- I am authorized to access, use, and disclose only the "minimum necessary" PRISM information required to perform my job duties.
- I will disclose PRISM information only to individuals who have legal authority to access the information.
- I will not use my PRISM access to look up or view information about family members, friends, the relatives or friends of other employees, or any persons who are not directly related to my assigned job duties.

Confidentiality and Security of PRISM Information

- I will protect the confidentiality and security of all PRISM information I am authorized to access, use, and/or disclose by strictly adhering to the terms of this Agreement.
- I will access PRISM information only on secure workstations in non-public areas. I will use only my User ID and password to access PRISM information, and I will protect my password from disclosure and not allow anyone to access PRISM information with my User ID and password.
- I will immediately inform my PRISM Lead of any actual or potential security breaches involving PRISM information, or of any access to or use of PRISM information by unauthorized users.
- I will not discuss PRISM information in public spaces in a manner in which unauthorized individuals could overhear such information, nor will I discuss PRISM information with unauthorized individuals, including spouses, domestic partners, family members, and/or friends.
- I will not make copies of PRISM information nor print PRISM screens unless necessary to perform my assigned job duties. I will not transfer any PRISM information to a portable electronic device or medium, nor remove PRISM information on a portable device or medium from facility premises, unless the information is encrypted and I have obtained prior permission from my PRISM Lead.

Violation of Agreement

- I understand that any intentional or unintentional violation of the terms of this Agreement must be reported immediately to my PRISM Lead and may result in disciplinary action and/or revocation of privileges to access and use PRISM information.
- I understand that information about violations of this Agreement and/or breaches of confidentiality may be forwarded to appropriate authorities for possible civil and/or criminal remedies.

Authorized Uses of PRISM Information

Please check all the activities below for which you need access to PRISM information.

Treatment

- ☐ T1 **Provision, Coordination, or Management of Health Care and Related Services** by one or more health care or service providers, including the coordination or management of health care by a health care or service provider with a third party.
- ☐ T2 **Consultation** between health care or service providers relating to a patient or client.
- ☐ T3 **Referral of a Patient or Client** for health care or services from one health care or service provider to another.

Health Care Operations

- ☐ H1 **Quality Assessment** and improvement activities, including caseload monitoring and management, and development of clinical guidelines.
- ☐ H2 **Population-Based Activities** relating to improving health or reducing health care cost.
- ☐ H3 **Case Management** and care coordination, including contacting other health care and social service providers and/or patients/clients with information about treatment or services alternatives.

If you need to use PRISM information for an activity not listed above, please explain:

Limits on PRISM Access

DSHS and HCA will limit the users' PRISM access to those clients for whom it is determined the user has a legitimate reason to view.

Frequency of Execution and Disposition Instructions

The PRISM Registration Form and User Agreement will be reviewed and signed by each PRISM User and PRISM Lead annually. Provide the PRISM User with a copy of this form and send a PDF of the signed form to the DSHS PRISM Administrator. Retain the original of each execution of this form in the employee's personnel file for six years.

PRISM User's Signature

I understand my responsibility for protecting the confidentiality and security of PRISM information. By signing below, I agree to comply with and be bound by the terms of the PRISM User Agreement.

PRISM USER'S SIGNATURE	DATE	PRISM USER'S PRINTED NAME

PRISM Lead's Signature

This employee has successfully completed appropriate confidentiality and security training within the past year.

☐ **YES**: Date of training: ☐ **NO**: Date training will be provided:

PRISM LEAD'S SIGNATURE	DATE	PRISM LEAD'S PRINTED NAME

FOR OFFICE USE ONLY: Addendum to DSHS / HCA Data Use Agreement (DUA) for Dual Eligibles

Assigned DUA Number:

CMS REPRESENTATIVE'S SIGNATURE	DATE

CMS PROJECT OFFICER'S SIGNATURE (IF APPLICABLE)	DATE

PDF this document to the PRISM Administrator at: PRISM.admin@dshs.wa.gov

I. EVALUATION AND RESEARCH COMMITTEE

1.0 POLICY TITLE: EVALUATION AND RESEARCH COMMITTEE

1.1 Originally Implemented: April 14, 2003

1.2 Reviewed and revised: November 2014

1.3 Officially Adopted: January 2, 2015

1.4 Effective Date: February 2, 2015

1.5 Signed:
Jim Vollendroff, Division Director

2.0 PURPOSE: To define the purpose and goals of the King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) Evaluation and Research Committee and the legal requirements to be met by the review process.

3.0 POLICIES AND PROCEDURES:

3.1 King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) will review and approve research studies in order to promote client confidentiality, informed consent and good research practices that protect clients in research and related activities directed, sponsored or approved by MHCADSD.

3.2 MHCADSD, through the Evaluation and Research Committee, shall provide oversight to all evaluation and research activities that fall within its purview in order to ensure compliance with the policies and procedures in this manual.

3.3 Any research and/or evaluation activities that involves data from MHCADSD information systems or any data collected and maintained by MHCADSD must be reviewed and acted upon by the Evaluation and Research Committee prior to the initiation of such activity.

3.4 Approval from the Evaluation and Research Committee or a data-sharing agreement does not eliminate the requirement for a consent from the client when it would otherwise be required.

3.5 The MHCADSD Evaluation and Research Committee will:

3.5.1 Review all evaluation and research proposals involving data and/or staff resources obtained or supported by MHCADSD funds to ensure that activities are consistent with the policies outlined in this manual.

3.5.2 For approved proposals, facilitate fulfillment of the MHCADSD responsibilities as specified in the proposal.

3.5.3 Work with the involved Institutional Review Board (IRB) (s) to coordinate and facilitate the approval process.

3.5.4 Work with the Privacy and Security Committee to monitor researchers'/evaluators' electronic access to MHCADSD data.

3.5.5 Review submitted proposals.

3.5.6 Monitor completion of approved projects.

3.5.7 Monitor annual IRB renewals. The Evaluation and Research Committee may request an annual copy of study modifications submitted to an IRB when the modifications affect how MHCADSD data is collected, used or disclosed.

3.5.8 Monitor and track all disclosures of protected health information approved by the Evaluation and Research Committee so that this information is available if a client requests an accounting of disclosures. The accounting must include disclosures of protected health information that occurred during the six years (or such shorter time period at the request of the client) prior to the date of the request for accouting. The following information must be provided to a client who requests such an accounting.[1]

A. Name of the protocol or the research activity:

B. A description of the research protocol or other research activity, including the purpose of the research and the criteria for selecting particular records;

C. A brief description of the type of protected health information disclosed;

D. The date or period of time during which such disclosures occurred, or may have occurred, including the date of the last such disclosure;

E. The name, address, and telephone number of the entity that sponsored the research/evaluation and of the researcher/evaluator to whom the information was disclosed; and

F. A statement that the protected health information of the client may or may not have been disclosed for a particular protocol or other research activity.

3.5.9 If MHCADSD provides an accounting for research/evaluation disclosures, and it is reasonably likely that the protected health information of the individual was disclosed for such research/evaluation protocol or activity, MHCADSD will, at the request of the individual, assist in contacting the entity that sponsored the research/evaluation and the researcher/evaluator.

3.6 Requests to the Evaluation and Research Committee for review of evaluation and research activities will be conducted as follows:

[1] 45 CFR 164.528(b)(4)

3.6.1 Researchers/Evaluators proposing studies utilizing MHCADSD data must submit the Evaluation and Research Proposal Application and Checklist and all required materials. The Evaluation and Research Committee will retain records of all reviewed studies for a period of seven years from study/evaluation completion.

3.6.2 Prior to submitting a proposal, the requester must have a consultation with an Evaluation and Research Committee member. If identified or identifiable data is being requested from MHCADSD, the requester must also have a consultation with the MHCADSD Privacy Officer prior to proposal submission.

3.6.3 Subject to the requirements of 42 CFR Part 2 and 45 CFR Part 164, individuals or agencies shall present project materials for Human Research Subject Review (HRSR) at an IRB, if required. Projects may be submitted simultaneously to the IRB and MHCADSD, but final approval by MHCADSD will not be given until the IRB or Privacy Board approval or a waiver is obtained. This documentation shall be submitted to the Evaluation and Research Committee prior to final approval of the research. If the IRB has waived the requirement for an authorization or has approved an alteration of the authorization requirement, then the researcher shall present a statement that the IRB has determined that the waiver of authorization satisfies the criteria found in 45 CFR Part 164.512(i).

3.6.4 The requester shall provide a brief description of the protected health information for which use or access has been determined to be necessary by the IRB[2]. (That is, the minimum necessary information without which the research would not be practical.)

3.6.5 The requester shall provide a description of the purpose(s) for which the data is requested.

3.6.6 All researchers/evaluators that request access to MHCADSD data shall use and sign a data use agreement that meets the requirements of 45 CFR 164.514 (e)(4). An acceptable data-sharing agreement template can be found on the MHCADSD Information for Researchers webpage. The specifics of each data-sharing agreement will be developed in collaboration by the researcher/evaluator and MHCADSD Privacy Officer.

A. The MHCADSD Privacy Officer may consult with the MHCADSD Privacy and Security Committee prior to approving the data-sharing agreement.

B. The data sharing agreement must be signed and executed prior to the release of any data from MHCADSD to the requester.

[2] 45 CFR 164.512 (i)(2)(ii)(C) and (iv)

C. A researcher/evaluator may request a "limited data set" as defined by 45 CFR Part 164.514(e). This use shall require a limited data use agreement. An acceptable limited data use agreement template is found on the MHCADSD Information for Researchers webpage.

3.6.7 If a researcher/evaluator requires data from MHCADSD, the data set will be created by MHCADSD subject to available resources. The requester must clearly specify what they expect MHCADSD staff to do with respect to the data set and what the requester will do. A proposal may not be approved if the resources are not available.

3.6.8 If a researcher/evaluator requests access to a specific client's data, provision may be made for MHCADSD personnel to obtain specified information for the researcher/evaluator subject to resources available. In such cases, the researcher/evaluator shall provide MHCADSD with a copy of the authorization for release of information signed by the client. This copy will be kept in the client's file or in a central file if there is no paper file for the client.

3.6.9 The Evaluation and Research Committee will endeavor to review each proposal within a month of when it was received. Applications must be received a minimum of one week prior to the next scheduled committee meeting to be reviewed.

3.6.10 The Evaluation and Research Committee Chair will notify the researcher/evaluator of the Committee's decision. If the project is approved, a designated committee member will be identified as a primary liaison to the researcher/evaluator for the life of the project.

3.6.11 All research/evaluation approved by the Evaluation and Research Committee shall adhere to the fully executed data sharing agreement between the researcher/evaluator and MHCADSD. In accordance with this agreement, all individuals having access to confidential information – whether electronic or non-electronic – shall have a completed oath of confidentiality on file with MHCADSD. All individuals accessing confidential information shall submit written verification of HIPAA, and when relevant, human subjects training.

3.7 While study/evaluation design and methodology of the project results are the responsibility of the project researcher/evaluator, MHCADSD requests immediate notification (at the same time that the IRB is notified and before any more data is accessed) in the event of significant protocol changes, protocol changes that impact how MHCADSD data is collected, used or disclosed, or any adverse unforeseen events throughout all phases of the project. This specifically refers to any events that would have to be reported to the IRB that approved the protocol.

3.8 When approval is granted, it shall be for one year, renewable annually, unless the IRB approval terminates sooner. IRB-approved research may not proceed after IRB approval has expired or been rescinded. Researchers must provide the Evaluation and Research Committee a copy of the annual IRB renewal letter.

3.9 All approvals are conditional based on adherence to this policy and conditions negotiated during the approval process. Approval may be rescinded if all conditions are not met.

3.10 A final report and a copy of publications shall be provided to the Evaluation and Research Committee at the conclusion of the project.

3.11 Research/evaluation results shall be shared with MHCADSD and MHCADSD shall be allowed to use or share with contractors or other government entities any product or information without censure or cost.

3.12 MHCADSD data may be used only for the purposes outlined in the approved project.

4.0 RESPONSIBILITIES:

4.1 MHCADSD is responsible for maintaining and supporting the Evaluation and Research Committee.

4.2 The Evaluation and Research Committee is responsible for preliminary review and waiving, approving or disapproving proposed research and/or evaluation activities in a timely fashion.

4.3 The Privacy Officer is responsible for review and approval of oaths of confidentiality and applications for access to the MHCADSD electronic client information.

4.4 Institutional Review Boards (IRBs) at the researcher's institution(s) or with jurisdiction over the research are responsible for the human subjects review of all research utilizing human subjects as required in 45 CFR Part 46 and 45 CFR Parts 160 and 164 (HIPAA).

4.5 Researchers/evaluators who intend to access MHCADSD data or use an MHCADSD database to identify or recruit clients for their research study are responsible for following this policy.

5.0 REFERENCES:

Washington State Laws, Regulations, and Policy including any successor, amended, or replacement laws, regulations, or policies

- Chapter 388-04 Washington Administrative Code (WAC) – Protection of Human Research Subjects
- Chapter 388-877[3] WAC – Community Mental Health and Involuntary Treatment Programs
- Chapter 10.77 RCW – Criminal Procedure – Criminally Insane
- Chapter 42.48 RCW – Release of Records for Research
- Title 70 RCW – Public Health & Safety

[3] See 388-877-0600 Individual Rights

- Chapter 70.02 RCW – Medical Records – Health Care Information Access and Disclosure[4]
- Chapter 70.96A RCW – Treatment for Alcoholism, Intoxication, and Drug Addiction[5]
- Title 71 RCW – Mental Illness
- Chapter 71.05 RCW – Mental Illness[6]
- Chapter 71.24 RCW – Community Mental Health Services Act
- Chapter 71.34 RCW – Mental Health Services for Minors[7]

Federal Law, Regulations, and Policy including any successor, amended, or replacement laws, regulations, or policies

- 42 CFR Part 2 – Public Health Service, Department of Health and Human Services, Confidentiality of Alcohol and Drug Abuse Patient Records
- 45 CFR Part 46 – Protection of Human Subjects. The Public Health Act as Amended by the Health Research Extension Act of 1985[8]
- 45 CFR Parts 160 and 164 – Standards for Privacy of Individually Identifiable Health Information

[4] See 70.02.050

[5] See 70.96A.150

[6] See 71.05.390 Confidential information and records – disclosures and 71.05.630 Treatment records – Confidential – Release.

[7] See 71.34.200 Information concerning treatment of minors confidential – Disclosure – Admissible as evidence with written consent.

[8] See 45 CFR 164.512(i)

XIV. PROGRAM INTEGRITY

1.0 POLICY TITLE: PROGRAM INTEGRITY

1.1 Originally Implemented: January 1, 2012

1.2 Reviewed and revised: November 2014

1.3 Officially Adopted: January 2, 2015

1.4 Effective Date: February 2, 2015

1.5 Signed: _____
Jean Robertson, Assistant Division Director/RSN Administrator

2.0 PURPOSE: To ensure the King County Mental Health Plan (KCMHP) and its provider network comply with requirements of the federal Deficit Reduction Act of 2005 and the False Claims Act.

3.0 POLICY/PROCEDURES/RESPONSIBILTIES: PROGRAM INTEGRITY

The King County Mental Health Plan (KCMHP) and its provider network shall take the following steps to comply with requirements of the Deficit Reduction Act and False Claims Act that protect the integrity of the Medicaid program:

3.1 Prohibit Medicaid payments to individuals and entities excluded from receiving Medicaid funds, recover overpayments, and impose sanctions as appropriate.

3.2 Maintain a plan to prevent, reduce, detect, correct, and report known or suspected fraud, waste, and abuse activities that includes:

3.2.1 A monitoring system to verify services are actually provided;

3.2.2 A process to report suspected fraud, waste, and abuse;

3.2.3 Enforcement through disciplinary actions;

3.2.4 Policies about the False Claims Act;

3.2.5 Education and training for employees about fraud and false claims laws; and

3.2.6 Whistleblower protections under the laws.

4.0 EXCLUDED PROVIDERS:

4.1 Policy Statement

The KCMHP and its providers are prohibited from using Medicaid funds to pay for goods and services furnished, ordered, or prescribed by excluded individuals and entities. (Attachments A and B).

4.2 Definitions

4.2.1 Excluded Individuals or Entities: individuals or entities that have been placed in non-eligible participant status under Medicare, Medicaid, and other federal or state health care programs. Exclusions may occur due to Office of Inspector General sanctions, failure to renew license or certification registration, revocation of professional license or certification, or termination by the state Medicaid agency.

4.2.2 Medicaid Integrity: planning, prevention, detection, and investigation/recovery activities undertaken to minimize or prevent overpayments due to Medicaid fraud, waste, or abuse.

4.2.3 Ownership or Control Interest: an individual or entity is considered to have an ownership or control interest if they have direct or indirect ownership of five percent or more or are a managing employee (e.g., a general manager, business manager, administrator, or director) who exercises operational or managerial control, or who directly or indirectly conducts day-to-day operations (Social Security Act (SSA) §1126(b), 42 Code of Federal Regulations (CFR) 455.104(a), and 42 CFR 1001.1001(a)(1) or any successors).

4.3 Monitoring

The KCMHP and its providers shall each respectively monitor for excluded individuals and entities by:

4.3.1 Screening employees and individuals and entities with an ownership or control interests for excluded individuals and entities prior to entering into a contractual or other relationship where the individual or entity would benefit directly or indirectly from receiving Medicaid funds.

4.3.2 Screening monthly newly added employees and individuals and entities with an ownership or control interest for excluded individuals and entities that would benefit directly or indirectly from receiving Medicaid funds.

4.3.3 Screening monthly employees and individuals and entities with an ownership or control interest that would benefit from receiving Medicaid funds for newly added excluded individuals and entities.

4.4 Reporting

Providers shall report to KCMHP and KCMHP shall report to Washington State Division of Social and Health Services (DSHS):

4.4.1 Any excluded individuals and entities discovered in the screening within 10 business days;

4.4.2 Any Medicaid payments made by KCMHP or a provider that directly or indirectly benefit excluded individuals and entities and the recovery of such payments;

4.4.3 Any actions taken by KCMHP or the provider to terminate the relationship with employees and individuals with an ownership or control interest discovered in the screening;

4.4.4 Any employees and individuals with an ownership or control interest convicted of any criminal or civil offense described in SSA section 1128 within 10 business days of KCMHP or the provider becoming aware of the conviction;

4.4.5 Any subcontractor termination for cause within 10 business days of the effective date of termination to include full details of the reason for termination; and

4.4.6 The KCMHP and its providers shall maintain an up-to-date list of individuals and entities with an ownership or control interest and make that list available upon request.

4.5 Enforcement

The KCMHP and its providers will:

4.5.1 Not make any Medicaid payments for goods or services that directly or indirectly benefit any excluded individual or entity;

4.5.2 Immediately recover any Medicaid payments for goods and services that benefit excluded individuals and entities discovered by KCMHP or its providers; and

4.5.3 Immediately terminate any employment, contractual, and control relationships with an excluded individual and entities discovered by KCMHP or its providers.

4.6 Penalties

Civil monetary penalties may be imposed against KCMHP or a provider if it employs or enters into a contract with an excluded individual or entity to provide goods or services to enrollees (SSA §1128A(a)(6) and 42 CFR 1003.102(a)(2) or any successors).

4.7 Termination

In addition, if KCMHP notifies a provider that an individual or entity is excluded from participation in the KCMHP provider network, the provider shall terminate all beneficial, employment, contractual, and control relationships with the excluded individual or entity immediately (Washington Administrative Code [WAC] 388-502-0030 or its successor).

4.8 The list of excluded individuals will be found at: http://www.oig.hhs.gov/fraud/exclusions.asp

4.9 SSA section 1128 will be found at: http://www.ssa.gov/OP_Home/ssact/title11/1128.htm

5.0 FRAUD, WASTE, AND ABUSE COMPLIANCE PLAN:

5.1 Policy Statement

The KCMHP shall guard against fraud and abuse practices and have a Fraud, Waste, and Abuse Plan (Plan) that directs how to do so in accordance with KCMHP's fundamental policy that all business shall be conducted in compliance with state and federal requirements and all applicable federal and state laws and regulations, including:

5.1.1 42 CFR Part 438 Subpart H or its successor;

5.1.2 31 United States Code (U.S.C.) 3729-3733 (the federal False Claims Act) (see Attachment C);

5.1.3 31 U.S.C. Chapter 38 (see Attachment D);

5.1.4 42 U.S.C. 1396a;

5.1.5 The federal Deficit Reduction Act of 2005 (section 6023);

5.1.6 1902(a)(68) of the Social Security Act (see Attachment C);

5.1.7 RCW 48.80 State Health Care False Claim Act or its successor; and

5.1.8 Other applicable local laws and ordinances.

5.2 Purpose

To outline the scope, responsibilities, and activities conducted by KCMHP to prevent and promptly identify and report instances of fraud, waste, and abuse, and take corrective action when necessary.

5.3 Definitions

5.3.1 Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. Abuse also includes beneficiary practices that result in unnecessary cost to the KCMHP.

Medicaid Managed Care Abuse means practices in a capitated MCO, PIHP program, or other managed care setting that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or contractual obligations for health care. The abuse can be committed by an MCO, contractor, subcontractor, provider, state employee, Medicaid beneficiary, or Medicaid managed care enrollee, among others. It also

includes beneficiary practices in a capitated MCO, PIHP program, or other managed care setting that result in unnecessary cost to the Medicaid program, or MCO, contractor, subcontractor, or provider. A provider can be defined as any individual or entity that receives Medicaid funds in exchange for providing a service (MCO, contractor, or subcontractor). It should be noted that Medicaid funds paid to an MCO, and then passed to subcontractors, are still Medicaid funds from a fraud and abuse perspective.

5.3.2 Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Medicaid Managed Care Fraud means any type of intentional deception or misrepresentation made by an entity or person in a capitated MCO, PIHP program, or other managed care setting with the knowledge that the deception could result in some unauthorized benefit to the entity, himself or some other person. A provider can be defined as any individual or entity that receives Medicaid funds in exchange for providing a service (MCO, contractor, or subcontractor).

5.3.3 Persons associated with KCMHP: All board members, consultants, KCMHP employees, and agencies receiving KCMHP funding to support mental health services.

5.3.4 Provider: Any individual or entity providing KCMHP-funded mental health services through contractual agreement with KCMHP.

5.3.5 Waste: The expenditure or allocation of resources or provision of services significantly in excess of need. Waste need not necessarily involve an element of private use nor of personal gain, but invariably signifies poor management resulting in the misuse of resources.

Fraud, Waste, and Abuse can include but are not limited to:

A. Billing for or Reporting of Services Not Performed;

B. Phantom Patients;

C. Double Billing or Reporting;

D. Unnecessary Services;

E. Kickbacks;

F. Upcoding (in a fee for service payment model);

G. Unbundling (in a fee for service payment model);

H. Falsification of Health Care Provider Credentials;

I. Falsification of Provider Financial Solvency;

J. Intentional improper billing;

K. Related Party Contracting;

L. Incentives that limit services or referral;

M. Embezzlement and theft;

N. Billing Medicaid enrollees for Medicaid covered services;

O. Using an inefficient or improperly trained coder whose inefficiency creates errors such as upcoding or double billing;

P. Neglecting to properly examine service records and as a result claiming a service or services when the client was not seen by the provider;

Q. Incurring unnecessary costs as a result of inefficient or ineffective practices, systems, or controls;

R. Continuing to provide a service when the client is no longer benefiting from the service; and/or

S. Renewing an outpatient benefit at the same or higher level as the previous benefit when service utilization does not warrant it.

5.4 Compliance Officer and Committee:

5.4.1 Compliance Officer

KCMHP has appointed the KCMHP Contracts Coordinator as the Fraud, Waste, and Abuse Compliance Officer (FWACO) (also known as the Program Integrity Officer (PIO) under the Medicaid program) who will be responsible for overseeing the Plan and coordinating monitoring activities.

5.4.2 Compliance Committee

A. The KCMHP Plan Management Group, comprised of KCMHP senior management, serves as the Compliance Committee (CC).

B. The FWACO reports to the CC.

C. The CC reports to the King County Mental Health, Chemical Abuse and Dependency Services Division Director.

D. While the FWACO generally reports to the CC, the FWACO always has the right to directly meet with the Division Director and consult with the King County Auditor if the circumstances warrant (e.g., in case of CC inaction).

5.4.3 In consultation with the CC, the FWACO may revise the Plan, as appropriate. The FWACO duties include the following:

A. To oversee and monitor KCMHP compliance activities;

B. To report on a periodic basis to the CC and the Division Director on the progress of implementation of the Plan;

C. To assist the Division Director, the Chief Operations Officer of the Mental Health Plan, and the CC in establishing methods to reduce KCMHP vulnerability to fraud, waste, and abuse;

D. To periodically review the Plan and recommend revisions as necessary;

E. To coordinate internal auditing and monitoring activities within KCMHP and to establish procedures for periodic compliance site visits of the operations of providers;

F. To receive and investigate reports of possible violations of the Plan;

G. To develop corrective action plans to correct violations and prevent future incidents of noncompliance;

H. To develop policies that encourage employees and contractors to report suspected violations of the Plan without fear of retaliation;

I. Identify areas where corrective actions have been needed and, in consultation with the CC, develop strategies to improve compliance system-wide; and

J. As a part of the ongoing monitoring and auditing of the Plan, the FWACO, in cooperation with the CC, establishes mechanism to notify employees and contractors of changes in laws, regulations, or policies, as necessary, to ensure continued compliance.

5.5 Monitoring

Detection and prevention of fraud, waste, and abuse is conducted by KCMHP staff through the following activities:

5.5.1 KCMHP Conducted Provider Site Visits;

5.5.2 Monthly Invoice Verification;

5.5.3 Requirement of Annual Independent Audit;

5.5.4 Monthly Review of Management Indicators;

5.5.5 Review of Community Inpatient Claims;

5.5.6 Quality Review Team Ad Hoc Studies;

5.5.7 Ombuds Service reports;

5.5.8 Grievance Resolution Process;

5.5.9 Utilization Management Operations;

5.5.10 Review of State Mental Health Division (MHD) Provider Licensing Reports; and

5.5.11 Annual Credentialing Process for All Providers.

5.6 Provider Relations and Contracts

5.6.1 KCMHP does not enter into contracts or other arrangements with providers which, directly or indirectly, pay or offer to pay anything of value, in return for the referral of consumers to KCMHP for services paid by the Medicaid program or by any other federal health care program.

5.6.2 KCMHP does not enter into financial arrangements with providers that base compensation on the volume of Medicaid services provided.

5.6.3 In accordance with 42 CFR 438.604 or its successor, KCMHP certifies data submitted to the state. KCMHP does not approve nor cause claims to be submitted to the Medicaid program or any other federal health care program:

A. For services provided as a result of payments made in violation of §4.6.1 above;

B. For services that are not reasonable and necessary;

C. For services which cannot be supported by the documentation in the medical record;

D. KCMHP does not falsify or misrepresent facts concerning the delivery of services or payment of claims in connection with the Medicaid program or any other federal health care benefit program;

E. KCMHP does not provide incentives to providers to reduce or limit medically necessary mental health services to Medicaid beneficiaries or recipients of other federal health care programs;

F. KCMHP conducts all business with providers at arm’s length and pursuant to written contract;

G. No employee or person associated with KCMHP prevents or delays the communication of information or records related to violation of the Plan to the FWACO; and

H. Individuals and agencies listed by a federal agency as excluded or otherwise ineligible for federal program participation, as required by current federal and state laws, or found to have a conviction or sanction

related to health care, will be excluded from providing KCMHP-funded services as described above.

5.6.4 Contractors are made aware of their obligation to report to KCMHP their good faith belief of any possible instances of non-compliance through terms identified in the King County Contract and KCMHP Policy and Procedures.

5.6.5 The Plan and reporting requirements are referenced in provider contracts.

5.6.6 KCMHP will notify subcontractors of applicable fraud, waste, and abuse training opportunities offered through the Centers for Medicare and Medicaid Services, the state MHD, or the KCMHP.

5.7 Provider Responsibilities

5.7.1 Providers and their subcontractors shall guard against fraud, waste, and abuse through prudent fiscal, and record keeping policies, procedures, and/or practices.

5.7.2 Provide employee education about False Claims Recovery (Attachment F).

5.7.3 Providers that make or receive $5 million or more in Medicaid payments in a preceding federal fiscal year must establish and adopt written policies about the False Claims Act and other provisions named in section 1902(a)(68) of the Social Security Act for all its employees, contractors, and agents (Attachment E).

A. Future determinations regarding a provider's responsibility for this requirement will be made by January 1 of each subsequent year based on payments either received or made in the preceding federal fiscal year.

B. If the provider furnishes services at more than a single location or under more than one contract, these provisions apply if the aggregate payments to the provider meet the $5 million threshold. This applies whether the provider uses one or more provider-identification or tax-identification numbers.

5.7.4 Providers must comply with all reporting and other anti-fraud, anti-waste, and anti-abuse requirements.

5.7.5 Providers shall not bill Medicaid enrollees for Medicaid covered services.

5.7.6 Providers must cooperate with the KCMHP and the Washington State Attorney General's Medicaid Fraud Control Unit relevant to any investigation of alleged fraud or abuse.

5.7.7 Providers shall implement procedures to screen employees and subcontractors to determine whether they have been listed by a federal agency as excluded or otherwise ineligible for federal program participation as described above.

5.7.8 Providers shall report all incidents of abuse, waste, and fraudulent activities to the KCMHP FWACO per section 5.9.

5.7.9 Providers shall not provide incentives to providers to reduce or limit medically necessary mental health services to Medicaid beneficiaries or recipients of other federal health care programs.

5.8 Education and Training

5.8.1 All KCMHP employees involved with contracting for services annually shall complete the King County Statement of Financial and Other Interests Form.

5.8.2 All KCMHP employees, at hire, shall receive training on the Plan and a copy of the KCMHP Fraud, Waste, and Abuse Compliance Plan and False Claims Act. In addition, training shall be provided annually at all-staff meetings by the KCMHP FWACO for all employees on their responsibilities to report non-compliance. Training addresses the following:

A. KCMHP commitment to compliance with all laws, regulations, and guidelines of Federal and state programs;

B. The elements of the Plan and False Claims Act (see Attachment F);

C. An overview of what constitutes fraud, waste, and abuse in a Medicaid Managed Care environment; and

D. The consequences of failing to comply with applicable laws.

5.9 Developing Effective Lines of Communication

5.9.1 An open line of communication between the FWACO and employees or others associated with KCMHP is critical to the successful implementation and operation of the Plan.

A. All employees and persons associated with KCMHP have a duty to report all incidents of abuse, waste, and fraudulent activities to the FWACO.

B. A report is made in any of the following ways:

1. In person, to the FWACO;

2. By faxing the FWACO at 206-296-0583;

3. By calling, on an anonymous basis, the FWACO at 206-263-8982; or

4. By mailing a written concern to:
Fraud, Waste, and Abuse Compliance Officer
King County Mental Health, Chemical Abuse and Dependency Services Division
The Chinook Building
410 Fifth Ave, Suite 400
Seattle, WA 98104

C. In addition, any person may seek guidance with respect to the Plan at any time by following the same reporting mechanisms outlined above.

5.9.2 The process for an investigation of a report is as follows:

A. Upon notification of a suspected instance of non-compliance the FWACO will conduct an initial investigation. If it appears there are genuine compliance concerns, the FWACO promptly informs the CC and the State Mental Health Division (MHD). Information provided to the CC and MHD will include:

1. The source of the complaint;

2. The involved employee or subcontractor;

3. The nature of the fraud or abuse complaint;

4. Approximate dollars involved; and

5. The legal and administrative disposition of the case.

B. The FWACO presents the recommended corrective action plan to the CC. The CC, after consideration and any modification, forwards the corrective action to the Division Director. Upon approval of the Division Director, the FWACO and CC develop a strategy for implementation of the corrective action plan, with the advice and guidance of County Auditor as needed. The corrective action plan is designed to ensure that the specific violation is addressed and, to the extent possible, that a similar problem does not occur in other departments or areas, and appropriate education activities are included.

If the investigation reveals possible criminal activity, the corrective action plan includes:

1. Immediate cessation of the activity until the corrective action is in place;

2. Initiation of appropriate disciplinary action against the person or persons involved in the activity;

3. Notification to such law enforcement and regulatory authorities as legal counsel advises, which at a minimum includes, for Medicaid fraud, notification to the:

a. Medicaid Fraud Unit of the Washington Attorney General's office; and

b. Director of the Managed Care Contracting Division of the Department of Health Care Policy and Financing;

4. Appropriate education of employees and those associated with KCMHP to prevent future similar problems; and

5. Initiation of any necessary action to ensure that no consumers are placed at clinical risk.

6. If the review results in conclusions or findings that the activity is not a violation of the Plan or that the activity did not occur as alleged, the investigation is closed.

C. Any threat of reprisal against a person who makes a good faith report under the Plan is against KCMHP policy. Reprisal, if found to be substantiated, is subject to appropriate discipline, up to and including termination.

D. Any attempt to harm or slander another through false accusations, malicious rumors, or other irresponsible actions is a violation of KCMHP policy. Such attempts, if found to be substantiated, shall be subject to discipline, up to and including termination.

E. KCMHP, at the request of a reporting person, shall provide such anonymity to the reporting person as is possible under the circumstances in the judgment of the FWACO, consistent with KCMHP obligation to investigate concerns and take necessary corrective action.

F. If the identity of the complainant is known, the FWACO provides a written report to the reporting individual that an investigation has been completed and, if appropriate, the corrective action that has been taken.

5.10 Enforcement through Disciplinary Measures

5.4.1 Employee Discipline

KCMHP will initiate appropriate disciplinary action against a person(s) whose conduct appears to have been intentional, willfully indifferent or in reckless disregard of state and federal laws.

5.4.2 Contractor Discipline/Termination

KCMHP contracts include provisions which require compliance with the Plan and clearly state that breach of these provisions will be grounds for corrective action or termination of the contract after failure to cure.

6.0 LIST OF ATTACHMENTS:

6.1 Attachment A: CMS Letter – Excluded Providers 01-16-2009

6.2 Attachment B: CMS Letter – Program Integrity 06-12-2008

6.3 Attachment C: False Claims Act

6.4 Attachment D: Administrative Remedies

6.5 Attachment E: Provider Requirements

6.6 Attachment F: Employee Education about False Claims Recovery

7.0 REFERENCES:

Federal Law, Regulations, and Policy including any successor, amended, or replacement laws, regulations, or policies

- SSA §1126 of the Act (Disclosure by Institutions, Organizations, and Agencies of Owners and Certain Other Individuals Who have been Convicted of Certain Offenses)
- SSA §1128 of the Act (Exclusion of Certain Individuals and Entities from Participation in Medicare and State Health Care Programs)
- SSA §1128A of the Act (Civil Monetary Penalties)
- SSA §1903 of the Act (Payment to States)
- 42 CFR Part 455 (Program Integrity: Medicaid)
- 42 CFR Part 1001 (Program Integrity—Medicare And State Health Care Programs)
- 42 CFR Part 1003 (Civil Money Penalties, Assessments And Exclusions)

Washington State Law, Regulations, and Policy including any successor, amended, or replacement laws, regulations, or policies

- Chapters 388-877, 388-877A WAC – Department of Social and Health Services – Mental Health – Community Mental Health and Involuntary Treatment Programs
- Federal 1915(b) Waiver Renewal

Other

- The current Department of Social and Health Services (DSHS) State Mental Health Contract and any subsequent amendments
- The current Department of Social and Health Services (DSHS) PIHP Contract and any subsequent amendments

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

SMDL #09-001

January 16, 2009

Dear State Medicaid Director:

The Center for Medicaid and State Operations (CMSO) is issuing this State Medicaid Director Letter to strengthen the integrity of the Medicaid program and help States reduce improper payments to providers. This letter advises States of their obligation to direct providers to screen their own employees and contractors for excluded persons. This letter specifically:

(1) Clarifies Federal statutory and regulatory prohibitions regarding Medicaid payments for any items or services furnished or ordered by individuals or entities that have been excluded from participation in Federal health care programs;

(2) Reminds States of the consequences for failure to prevent payments for items or services furnished or ordered by excluded individuals and entities;

(3) Sets forth the Centers for Medicare & Medicaid Services' (CMS) policy with respect to States' responsibility to communicate to providers their obligation to screen employees and contractors for excluded individuals and entities both prior to hiring or contracting and on a periodic basis, and the manner in which overpayment calculations should be made; and

(4) Identifies the List of Excluded Individuals/Entities (LEIE) as a resource providers may utilize to determine whether any of their employees and contractors has been excluded.

Background

The HHS Office of Inspector General (HHS-OIG) excludes individuals and entities from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and all Federal health care programs (as defined in section 1128B(f) of the Social Security Act (the Act)) based on the authority contained in various sections of the Act, including sections 1128, 1128A, and 1156.

When the HHS-OIG has excluded a provider, Federal health care programs (including Medicaid and SCHIP programs) are generally prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities. (Section 1903(i)(2) of the Act; and 42 CFR section 1001.1901(b)) This payment ban applies to any items or services reimbursable under a Medicaid program that are furnished by an excluded individual or entity, and extends to:

Page 2 – State Medicaid Director

- all methods of reimbursement, whether payment results from itemized claims, cost reports, fee schedules, or a prospective payment system;

- payment for administrative and management services not directly related to patient care, but that are a necessary component of providing items and services to Medicaid recipients, when those payments are reported on a cost report or are otherwise payable by the Medicaid program; and

- payment to cover an excluded individual's salary, expenses or fringe benefits, regardless of whether they provide direct patient care, when those payments are reported on a cost report or are otherwise payable by the Medicaid program.

In addition, no Medicaid payments can be made for any items or services directed or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known of the exclusion. This prohibition applies even when the Medicaid payment itself is made to another provider, practitioner or supplier that is not excluded. (42 CFR section 1001.1901(b))

The listing below sets forth some examples of types of items or services that are reimbursed by Medicaid which, when provided by excluded parties, are not reimbursable*:

- Services performed by excluded nurses, technicians, or other excluded individuals who work for a hospital, nursing home, home health agency or physician practice, where such services are related to administrative duties, preparation of surgical trays or review of treatment plans if such services are reimbursed directly or indirectly (such as through a pay per service or a bundled payment) by a Medicaid program, even if the individuals do not furnish direct care to Medicaid recipients;

- Services performed by excluded pharmacists or other excluded individuals who input prescription information for pharmacy billing or who are involved in any way in filling prescriptions for drugs reimbursed, directly or indirectly, by a Medicaid program;

- Services performed by excluded ambulance drivers, dispatchers and other employees involved in providing transportation reimbursed by a Medicaid program, to hospital patients or nursing home residents;

- Services performed for program recipients by excluded individuals who sell, deliver or refill orders for medical devices or equipment being reimbursed by a Medicaid program;

- Services performed by excluded social workers who are employed by health care entities to provide services to Medicaid recipients, and whose services are reimbursed, directly or indirectly, by a Medicaid program;

- Services performed by an excluded administrator, billing agent, accountant, claims processor or utilization reviewer that are related to and reimbursed, directly or indirectly, by a Medicaid program;

* This list is drawn from the 1999 HHS-OIG Special Advisory Bulletin: The Effect of Exclusion From Participation in Federal Health Care Programs.

Page 3 – State Medicaid Director

- Items or services provided to a Medicaid recipient by an excluded individual who works for an entity that has a contractual agreement with, and is paid by, a Medicaid program; and

- Items or equipment sold by an excluded manufacturer or supplier, used in the care or treatment of recipients and reimbursed, directly or indirectly, by a Medicaid program.

Consequences to States of Paying Excluded Providers

Because it is prohibited by Federal law from doing so, CMS shall make no payments to States for any amount expended for items or services (other than an emergency item or service not provided in a hospital emergency room) furnished under the plan by an individual or entity while being excluded from participation (unless the claim for payment meets an exception listed in 42 CFR section 1001.1901(c)). Any such payments actually claimed for Federal financial participation constitute an overpayment under sections 1903(d)(2)(A) and 1903(i)(2) of the Act, and are therefore subject to recoupment. It is thus incumbent on States to take all reasonable steps to prevent making payments that must ultimately be refunded to CMS.

Previous Guidance Regarding Preventing Payments For Goods and Services Furnished by Excluded Individuals and Entities

In a State Medicaid Director Letter issued on June 12, 2008, CMS notified States of their own obligation to attempt to determine whether an excluded individual has an ownership or control interest in an entity that is a Medicaid provider, and of States' obligation to report information regarding such excluded individuals to the HHS-OIG. In a State Medicaid Director Letter issued on March 17, 1999, and in a follow-up State Medicaid Director Letter issued on May 16, 2000 ("Medicare/Medicaid Sanction Reinstatement Report"), CMS described the HHS-OIG's authority to exclude persons based on actions taken by State Medicaid Agencies.

In the State Medicaid Director Letter dated May 16, 2000, CMS reminded States that the Medicare/Medicaid Sanction-Reinstatement Report, formerly known as HCFA Publication 69 and now replaced by the Medicare Exclusion Database (the MED) is a vital resource available to States for ascertaining and verifying whether an individual or entity is excluded and should not be receiving payments. The guidance also stated that the payment prohibition applies to any managed care organization contracting with an excluded party.

In a second State Medicaid Director Letter dated May 16, 2000 ("State's Obligation to notify the Department of Health and Human Services Office of Inspector General"), CMS reminded States of their responsibility to promptly notify the HHS-OIG of any action taken by a State to limit the ability of an individual or entity to participate in its program. *See* 42 CFR section 1002.3(b)(3).

Policy Clarification: States Should Advise Medicaid Providers to Screen for Exclusions

To further protect against payments for items and services furnished or ordered by excluded parties, States should advise all current providers and providers applying to participate in the Medicaid program to take the following steps to determine whether their employees and contractors are excluded individuals or entities:

- States should advise providers of their obligation to screen all employees and contractors to determine whether any of them have been excluded. States should communicate this obligation to providers upon enrollment and reenrollment.

- States should explicitly require providers to agree to comply with this obligation as a condition of enrollment.

- States should inform providers that they can search the HHS-OIG website by the names of any individual or entity.

- States should require providers to search the HHS-OIG website monthly to capture exclusions and reinstatements that have occurred since the last search.

- States should require that providers immediately report to them any exclusion information discovered.

This line of defense in combating fraud and abuse must be conducted accurately, thoroughly, and routinely. States must notify the HHS-OIG promptly of any administrative action the State takes against a provider for failure to comply with these screening and reporting obligations. *See* 42 CFR section 1002.3(b)(3). States can satisfy this obligation by communicating the relevant information to the appropriate Regional Office of the OIG Office of Investigations.

States also should inform providers that civil monetary penalties may be imposed against Medicaid providers and managed care entities (MCEs)† who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid recipients. (Section 1128A(a)(6) of the Act; and 42 CFR section 1003.102(a)(2))

Policy Clarification: Calculation of Overpayments to Excluded Individuals or Entities

As stated above, Federal health care programs, including Medicaid, are generally prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities. The amount of the Medicaid overpayment for such items or services is the actual amount of Medicaid dollars that were expended for those items or services. When Medicaid funds have been expended to pay an excluded individual's salary, expenses, or fringe benefits, the amount of the overpayment is the amount of those expended Medicaid funds. We recognize that there may be instances when the connection between expended Medicaid funds and the items or services furnished by the excluded individual or entity are too attenuated to trace. When such circumstances arise, the overpayment is no more than the amount which the State is certain was paid with Medicaid dollars.

† This State Medicaid Director Letter uses the term "managed care entity" to refer briefly to managed care organizations (MCOs), prepaid inpatient health plans, prepaid ambulatory health plans, and primary care case management (PCCM). States should not confuse this abbreviation with the statutory definition of managed care entity which only refers to MCOs and PCCMs. *See* section 1932(a)(1)(B) of the Act.

Page 5 – State Medicaid Director

Where Providers Can Look for Excluded Parties

While the MED is not readily available to providers, the HHS-OIG maintains the LEIE, a database accessible to the general public that provides information about parties excluded from participation in Medicare, Medicaid, and all other Federal health care programs. The LEIE website is located at http://www.oig.hhs.gov/fraud/exclusions.asp and is available in two formats. The online search engine identifies currently excluded individuals or entities. When a match is identified, it is possible for the searcher to verify the accuracy of the match using a Social Security Number (SSN) or Employer Identification Number (EIN). The downloadable version of the database may be compared against an existing database maintained by a provider. However, unlike the online format, the downloadable database does not contain SSNs or EINs.

Additionally, some States maintain their own exclusion lists, pursuant to 42 CFR section 1002.210 or State authority, which include individuals and entities whom the State has barred from participating in State government programs. States with such lists should remind providers that they are obligated to search their State list routinely whenever they search the LEIE.

Conclusion

We know you share our commitment to combating fraud and abuse. We all understand that provider enrollment is the first line of defense in this endeavor. If we strengthen our efforts to identify excluded parties, the integrity and quality of the Medicaid program will be improved, benefiting Medicaid recipients and taxpayers across the country.

If you have any questions or would like any additional information on this guidance, please direct your inquiries to Ms. Claudia Simonson, Centers for Medicare & Medicaid Services, Center for Medicaid and State Operations, Medicaid Integrity Group, 233 North Michigan Avenue, Suite 600, Chicago, Illinois 60601 or claudia.simonson@cms.hhs.gov. Thank you for your assistance in this important endeavor.

Sincerely,

/s/
Herb B. Kuhn
Deputy Administrator
Acting Director, Center for Medicaid and State Operations

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
Division of Medicaid and Children's Health

Ann C. Kohler
NASMD Executive Director
American Public Human Services Association

Page 6 – State Medicaid Director

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Debra Miller
Director for Health Policy
Council of State Governments

Christie Raniszewski Herrera
Director, Health and Human Services Task Force
American Legislative Exchange Council

Barbara W. Levine
Chief, Government Relations and Legal Affairs
Association of State and Territorial Health Officials

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

SMDL #08-003

June 12, 2008

Dear State Medicaid Director:

The Centers for Medicare & Medicaid Services (CMS) is issuing this State Medicaid Director Letter to strengthen the integrity of the Medicaid program and help States reduce improper payments to providers. This letter specifically:

(1) Clarifies CMS policy with respect to States' obligations to screen for excluded individuals and entities prior to and during provider enrollment;

(2) Reminds States of the obligation to report to the Health and Human Service Office of Inspector General (OIG) both convictions related to the Medicaid program and sanctions imposed by the State Medicaid Agency on Medicaid providers; and

(3) Reminds States of the consequences set forth in Federal laws and regulations for failure to prevent Medicaid participation by excluded individuals and entities.

Background

The OIG excludes individuals and entities from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and all Federal health care programs (as defined in section 1128B(f) of the Social Security Act (the Act)) based on the authority contained in various sections of the Act, including sections 1128, 1128A, 1156, and 1892.

When the OIG has excluded a provider, Federal health care programs (including Medicaid and SCHIP programs) are prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities until the provider has been reinstated by the OIG (42 CFR section 1001.1901). The only exception is when the OIG has waived the exclusion of an individual or entity. *See* sections 1128(c)(3)(B) and 1128(d)(3)(B) of the Act; and 42 CFR section 1001.1801. No State may waive such an exclusion, in whole or in part. Only the OIG has the authority to waive an exclusion that it has imposed. If a State believes that waiver of an exclusion is appropriate, it may submit a written request for such a waiver to the OIG (42 CFR section 1001.1801).

Additionally, section 1932(d)(1) of the Act prohibits managed care organizations (MCOs) and primary care case managers (PCCMs) from knowingly having a director, officer, partner, or person with a beneficial ownership of more than 5 percent of the entity's equity who is debarred, suspended, or excluded, or from having an employment, consulting, or other agreement with an individual or entity for the provision of items and services that are significant and material to the entity's obligations under its

contract with the State where the individual or entity is debarred, suspended, or excluded. Section 438.610 of the Federal managed care regulations extends the prohibition to prepaid inpatient health plans (PIHPs) and prepaid ambulatory health plans (PAHPs) (42 CFR section 438.610.) If a State finds that an MCO, PCCM, PIHP, or PAHP has a noncompliant relationship, the State must notify the Secretary of the noncompliance. The State may not renew or extend its agreement with the noncompliant entity unless the Secretary provides to the State and to Congress a written statement describing compelling reasons to renew or extend the agreement. Additional administrative sanctions applicable to MCEs are set forth in 42 CFR section 438.700 *et seq*.

Policy Clarification
States must determine whether current providers, managed care entities (MCEs) (i.e., MCOs, PCCMs, PIHPs, and PAHPs),* providers applying to participate in the Medicaid program, and individuals with an ownership or control interest in the provider entity or MCE are excluded individuals or entities. Since Federal regulations prohibit payment for items or services furnished by excluded individuals and entities, it is imperative that this first line of defense in combating fraud and abuse be conducted accurately, thoroughly, and routinely.

Previous Guidance
In a State Medicaid Director Letter issued on March 17, 1999, and in a follow-up State Medicaid Director Letter issued on May 16, 2000, CMS described the OIG's authority to exclude persons based on actions taken by State Medicaid Agencies.

In the State Medicaid Director Letter dated May 16, 2000, CMS reminded States that the Medicare/Medicaid Sanction-Reinstatement Report, formerly known as HCFA Publication 69 and now replaced by the Medicare Exclusion Database, discussed below, is a vital resource for ascertaining and verifying whether a provider is excluded and should not be receiving payments. The guidance also stated that the payment prohibition applies to any MCO contracting with an excluded party.

State Obligations Concerning Excluded Individuals and Entities
Federal statutes and regulations clearly prohibit States from paying for items or services furnished, ordered, or prescribed by excluded persons. States typically do screen for excluded providers prior to and after enrollment. However, not all States attempt to determine whether an excluded individual has an ownership or control interest, as defined below, in an entity that is a Medicaid provider. Federal regulations at 42 CFR section 1002.3 require States to report to OIG information regarding individuals that have ownership or control interests in provider entities and who have been convicted of a criminal offense as described in sections 1128(a) and 1128(b)(1), (2), or (3) of the Act, that have had civil monetary penalties imposed under section 1128A of the Act, or that have been excluded from participation in Medicare or any of the State health care programs, within 20 business days after the date the agency receives the information. If appropriate, OIG may permissively exclude the provider under section 1128(b)(8) of the Act and under 42 CFR section 1001.1001.

* While this *State Medicaid Director Letter* uses the term "managed care entity" to refer briefly to MCOs, PIHPs, PAHPs, and PCCMs, States should not confuse this abbreviation with the statutory definition of managed care entity, which only refers to MCOs and PCCMs. *See* section 1932(a)(1)(B) of the Act.

Page 3 – State Medicaid Director

General Rules

- States should solicit information from providers about individuals with ownership or control interests in the provider entity.

- In accordance with the rules set forth in this letter, States should search the Medicare Exclusion Database (MED) or the OIG List of Excluded Individuals/Entities (LEIE) database by the names of any individual, entity, or individual with ownership or control interest in any provider entity providing services for which payment is made under the Medicaid program or seeking to participate in the Medicaid program, including through a fee-for-service delivery system or through the State's managed care program or other waiver program.

- States should review provider enrollment eligibility upon enrollment or reenrollment.

- States should search the MED or the OIG Web site monthly to capture exclusions and reinstatements that have occurred since the last search.

- States should search the exclusions database for both in-State providers and out-of-State providers seeking to participate in the program.

- States should not process a provider's disclosure information that does not appear complete or does not include information on individuals with ownership or control interests in the provider entity, including managing employees, until the State verifies the accuracy and completeness of the information.

- States should report to OIG any exclusion information that is disclosed to them by a provider about an individual who has or had an ownership or control interest in a provider entity or who is a managing employee of a provider entity within 20 business days after receipt of such information.

- States must notify the OIG promptly if the State Medicaid Agency has taken any action on the provider's application for participation in the Medicaid program.

- States should notify the OIG promptly of any administrative action the State takes to limit a provider's participation in the Medicaid program that might lead to an exclusion.

Ownership and Control Interests

An individual is considered to have an ownership or control interest in a provider entity if it has direct or indirect ownership of 5 percent or more, or is a managing employee (e.g., a general manager, business manager, administrator, or director) who exercises operational or managerial control over the entity, or who directly or indirectly conducts the day-to-day operations of the entity as defined in section 1126(b) of the Act and under 42 CFR section 1001.1001(a)(1).

States must actively solicit information regarding individuals with ownership or control interests in provider entities from providers because providers may not independently disclose the identity of owners or managing employees on the disclosure document. State data files should capture these important data elements so that an automated comparison of exclusions against a provider file that

includes the names of individuals with ownership or control interests in provider entities can be accomplished easily during regular monthly searches and at any time providers submit new disclosure information to the State. While States may delegate many provider enrollment or credentialing functions to MCEs for the managed care program and to the States' contractors for Home and Community-Based Services (HCBS) and other waiver programs, the State remains responsible for ensuring that it does not pay an excluded provider for Medicaid health care items or services. States that delegate managed care and waiver program provider enrollment and credentialing to their MCEs and HCBS waiver contractors must mandate that the MCEs and HCBS waiver contractors search the exclusions database with the same frequency as the State for fee-for-service providers. MCEs and HCBS waiver contractors should search for providers, provider entities, and individuals with ownership or control interests in the provider entities.

Under Federal regulations at 42 CFR section 1002.3(a), providers entering into or renewing a provider agreement must disclose to the State Medicaid Agency the identity of any excluded individual with an ownership or control interest in the provider entity. The State Medicaid Agency then must notify the OIG of this information within 20 business days after the date the agency receives the information and must notify the OIG promptly if the State Medicaid Agency has taken any action on the provider's application for participation in the Medicaid program. 42 CFR section 1002.3 (b)(2). The OIG, in its discretion and under statutory and regulatory authority, may exclude that entity.

Convictions and Administrative Sanctions

Under 42 CFR section 1002.230, each State, either through its State Medicaid Agency or its Medicaid Fraud Control Unit (MFCU), must notify the OIG of convictions related to the delivery of items or services under the Medicaid program within 15 days after the conviction if the State agency was involved in the investigation or prosecution of the case, or within 15 days after the State agency learns of the conviction if the agency was not involved in the investigation or prosecution of the case. Such a report should include all the necessary documentation to support an exclusion action by the OIG.

Additionally, under 42 CFR section 1002.3, the State agency must notify the OIG of any disclosures made by providers with regard to the ownership or control by a person that has been convicted of a criminal offense described under sections 1128(a) and 1128(b)(1), (2), or (3) of the Act, or that has had civil money penalties or assessments imposed under section 1128A of the Act. *See* 42 CFR section 1001.1001(a)(1). The State Medicaid Agency must notify the OIG of this information within 20 business days after the date it receives the information. 42 CFR sections 455.106(b)(1) and 1002.3.

States are required under 42 CFR sections 455.106(b)(2) and 1002.3(b)(3) to notify the OIG promptly of any administrative action it takes to limit participation of a provider in the Medicaid program. Reporting these criminal and administrative actions is critical to timely implementation of exclusions of persons who have defrauded health care programs or harmed patients. Currently in some States, there are significant delays in reporting of such actions. Such delays jeopardize the government's ability to protect the Federal health care programs and their beneficiaries from untrustworthy persons.

Page 5 – State Medicaid Director

Where to Look for Excluded Parties

Medicare Exclusion Database

In 2002, HCFA Publication 69 was replaced by a new system of record called the Medicare Exclusion Database (MED). The MED was developed to collect and retrieve information that aided in ensuring that no payments are made to excluded individuals and entities for services furnished during the exclusion period. Two of the information sources used in populating the MED are the OIG Exclusion file and the Social Security Administration. MED files contain a variety of identifiable and general information including name, Social Security Number (SSN), employer identification number, Uniform Provider Identification Number, National Provider Identifier, address, exclusion type, and reinstatement date, if applicable. The five MED files are e-mailed to States every month. These files contain the month's new exclusions, new reinstatements, cumulative exclusions, cumulative reinstatements and non-MED data. MED files are also available through CMS' Application Portal.

List of Excluded Individuals/Entities

The OIG maintains the LEIE, a database that provides information about parties excluded from participation in Medicare, Medicaid, and all other Federal health care programs. The LEIE website is located at http://oig.hhs.gov/fraud/exclusions/listofexcluded.html and is available in two formats. The online search engine identifies currently excluded individuals or entities. When a match is identified, it is possible for the searcher to verify the accuracy of the match using a SSN or Employer Identification Number (EIN). The downloadable version of the database may be compared against State enrollment files. However, unlike the online format, the downloadable database does not contain SSNs or EINs.

When to Look for Excluded Parties

States should review provider enrollment eligibility whenever an individual or entity submits an application for enrollment or reenrollment in the program. Additionally, States should conduct searches on both in-State providers and out-of-State providers about which the State Medicaid Agency would not have received notice of exclusion. States should conduct the searches monthly via the MED or the OIG Web site to capture exclusions and reinstatements that have occurred since the last search.

Reminder of Consequences of Paying Excluded Providers

The CMS informed States in the State Medicaid Director Letter dated May 16, 2000, that under section 1903(i)(2) of the Act CMS shall make no payments to States for any amount expended for items or services (other than an emergency item or service not provided in a hospital emergency room) furnished under the plan by an individual or entity while being excluded from participation. This includes Medicare, Medicaid, SCHIP, and all Federal health care programs (as defined in section 1128B(f) of the Act) based on the authority contained in various sections of the Act, including sections 1128, 1128A, 1156, and 1892. Any such payments actually claimed for Federal financial participation (FFP) constitute an overpayment under section 1903(d)(2)(A) of the Act and are unallowable for FFP.

Further, States may not seek Federal reimbursement for payments to providers that have not provided required ownership and control disclosures, or other disclosures regarding business transactions, under 42 CFR sections 455.104 and 455.105. States may deny enrollment to a provider whose owner, agent, or managing employee has been convicted of a criminal offense relating to Medicare, Medicaid, or title XX programs. Moreover, States may deny enrollment or terminate a provider's enrollment if the State determines the provider did not fully disclose required criminal conviction information, under 42 CFR section 455.106(c).

Conclusion
We know you share our commitment to combating fraud and abuse and understand that provider enrollment is the first line of defense in this endeavor. If we strengthen our efforts to identify excluded parties, the integrity and quality of the Medicaid program will be improved, benefiting Medicaid beneficiaries and taxpayers across the country.

If you have any questions or would like any additional information on this guidance, please direct your inquiries to Ms. Claudia Simonson, Centers for Medicare & Medicaid Services, Center for Medicaid and State Operations, Medicaid Integrity Group, Division of Field Operations, 233 North Michigan Avenue, Suite 600, Chicago, IL 60601 or claudia.simonson@cms.hhs.gov. Thank you for your assistance in this important endeavor.

Sincerely,

/s/

Herb B. Kuhn
Deputy Administrator
Acting Director, Center for Medicaid and State Operations

cc:
CMS Regional Administrators

CMS Associate Regional Administrators
Division of Medicaid and Children's Health

Barbara Edwards
NASMD Interim Director
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Debra Miller
Director for Health Policy
Council of State Governments

Christie Raniszewski Herrera
Director, Health and Human Services Task Force
American Legislative Exchange Council

Barbara Levine
Director of Policy and Programs
Association of State and Territorial Health Officials

The False Claims Act

I. KCMHP and its providers shall comply with the provisions of the federal False Claims Act as established under:

A. Section 1902(a)(68) of the Social Security Act as detailed below.

Section 1902(a)(68) of the Social Security Act: (a) A State plan for medical assistance must—

(68) Provide that any entity that receives or makes annual payments under the State plan of at least $5,000,000, as a condition of receiving such payments, shall—

(A) Establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code[19], any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs(as defined in section 1128B(f));

(B) Include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and

(C) Include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

B. Sections 3729 through 3733 of title 31 United States Code as detailed below.

TITLE 31—MONEY AND FINANCE

§ 3729. False claims

(a) LIABILITY FOR CERTAIN ACTS.—Any person who—

(1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval;

(2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government;

(3) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid;

(4) has possession, custody, or control of property or money used, or to be used, by the Government and, intending to defraud the Government or willfully to conceal the property, delivers, or causes to be delivered, less property than the amount for which the person receives a certificate or receipt;

(5) authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;

(6) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge the property; or

(7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government,

is liable to the United States Government for a civil penalty of not less than **$5,000** and not more than **$10,000**, **plus 3 times the amount of damages** which the Government sustains because of the act of that person, except that if the court finds that—

(A) the person committing the violation of this subsection furnished officials of the United States responsible for investigating false claims violations with all information known to such person about the violation within 30 days after the date on which the defendant first obtained the information;

(B) such person fully cooperated with any Government investigation of such violation; and

(C) at the time such person furnished the United States with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under this title with respect to such violation, and the person did not have actual knowledge of the existence of an investigation into such violation;

the court may assess not less than 2 times the amount of damages which the Government sustains because of the act of the person. A person violating this subsection shall also be liable to the United States Government for the costs of a civil action brought to recover any such penalty or damages.

(b) KNOWING AND KNOWINGLY

DEFINED.—For purposes of this section, the terms ''*knowing*'' and ''*knowingly*'' mean that a person, with respect to information—

(1) has actual knowledge of the information;

(2) acts in deliberate ignorance of the truth or falsity of the information; or

(3) acts in reckless disregard of the truth or falsity of the information,

and no proof of specific intent to defraud is required.

(c) CLAIM DEFINED.—For purposes of this section, ''*claim*'' includes any request or demand, whether under a contract or otherwise, for money or property which is made to a contractor, grantee, or other recipient if the United States Government provides any portion of the money or property which is requested or demanded, or if the Government will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.

(d) EXEMPTION FROM DISCLOSURE.—Any information furnished pursuant to subparagraphs (A) through (C) of subsection (a) shall be exempt from disclosure under section 552 of title 5.

(e) EXCLUSION.—This section does not apply to claims, records, or statements made under the Internal Revenue Code of 1986.

§ 3730. Civil actions for false claims

(a) RESPONSIBILITIES OF THE ATTORNEY GENERAL.— The Attorney General diligently shall investigate a violation under section 3729. If the Attorney General finds that a person has violated or is violating section 3729, the Attorney General may bring a civil action under this section against the person.

(b) ACTIONS BY PRIVATE PERSONS.—

(1) A person may bring a civil action for a violation of section 3729 for the person and for the United States Government. The action shall be brought in the name of the Government. The action may be dismissed only if the court and the Attorney General give written consent to the dismissal and their reasons for consenting.

(2) A copy of the complaint and written disclosure of substantially all material evidence and information the person possesses shall be served on the Government pursuant to Rule 4(d)(4) of the Federal Rules of Civil Procedure. The complaint shall be filed in camera, shall remain under seal for at least 60 days, and shall not be served on the defendant until the court so orders. The Government may elect to intervene and proceed with the action within 60 days after it receives both the complaint and the material evidence and information.

(3) The Government may, for good cause shown, move the court for extensions of the time during which the complaint remains under seal under paragraph (2). Any such motions may be supported by affidavits or other submissions in camera. The defendant shall not be required to respond to any complaint filed under this section until 20 days after the complaint is unsealed and served upon the defendant pursuant to Rule 4 of the Federal Rules of Civil Procedure.

(4) Before the expiration of the 60-day period or any extensions obtained under paragraph (3), the Government shall—

(A) proceed with the action, in which case the action shall be conducted by the Government; or

(B) notify the court that it declines to take over the action, in which case the person bringing the action shall have the right to conduct the action.

(5) When a person brings an action under this subsection, no person other than the Government may intervene or bring a related action based on the facts underlying the pending action.

(c) RIGHTS OF THE PARTIES TO QUI TAM ACTIONS.—

(1) If the Government proceeds with the action, it shall have the primary responsibility for prosecuting the action, and shall not be bound by an act of the person bringing the action. Such person shall have the right to continue as a party to the action, subject to the limitations set forth in paragraph (2).

(2)(A) The Government may dismiss the action notwithstanding the objections of the person initiating the action if the person has been notified by the Government of the filing of the motion and the court has provided the person with an opportunity for a hearing on the motion.

(B) The Government may settle the action with the defendant notwithstanding the objections of the person initiating the action if the court determines, after a hearing, that the proposed settlement is fair, adequate, and reasonable under all the circumstances. Upon a showing of good cause, such hearing may be held in camera.

(C) Upon a showing by the Government that unrestricted participation during the course of the litigation by the person initiating the action would interfere with or unduly delay the Government's prosecution of the case, or would be repetitious, irrelevant, or for purposes of harassment, the court may, in its discretion, impose limitations on the person's participation, such as—

(i) limiting the number of witnesses the person may call;

(ii) limiting the length of the testimony of such witnesses;

(iii) limiting the person's cross-examination of witnesses; or

(iv) otherwise limiting the participation by the person in the litigation.

(D) Upon a showing by the defendant that unrestricted participation during the course of the litigation by the person initiating the action would be for purposes of harassment or would cause the defendant undue burden or unnecessary expense, the court may limit the participation by the person in the litigation.

(3) If the Government elects not to proceed with the action, the person who initiated the action shall have the right to conduct the action. If the Government so requests, it shall be served with copies of all pleadings filed in the action and shall be supplied with copies of all deposition transcripts (at the Government's expense). When a person proceeds with the action, the court, without limiting the status and rights of the person initiating the action, may nevertheless permit the Government to intervene at a later date upon a showing of good cause.

(4) Whether or not the Government proceeds with the action, upon a showing by the Government that certain actions of discovery by the person initiating the action would interfere with the Government's investigation or prosecution of a criminal or civil matter arising out of the same facts, the court may stay such discovery for a period of not more than 60 days. Such a showing shall be conducted in camera. The court may extend the 60-day period upon a further showing in camera that the Government has pursued the criminal or civil investigation or proceedings with reasonable diligence and any proposed discovery in the civil action will interfere with the ongoing criminal or civil investigation or proceedings.

(5) Notwithstanding subsection (b), the Government may elect to pursue its claim through any alternate remedy available to the Government, including any administrative proceeding to determine a civil money penalty. If any such alternate remedy is pursued in another proceeding, the person initiating the action shall have the same rights in such proceeding as such person would have had if the action had continued under this section. Any finding of fact or conclusion of law made in such other proceeding that has become final shall be conclusive on all parties to an action under this section. For purposes of the preceding sentence, a finding or conclusion is final if it has been finally determined on appeal to the appropriate court

of the United States, if all time for filing such an appeal with respect to the finding or conclusion has expired, or if the finding or conclusion is not subject to judicial review.

(d) AWARD TO QUI TAM PLAINTIFF.—

(1) If the Government proceeds with an action brought by a person under subsection (b), such person shall, subject to the second sentence of this paragraph, receive at least 15 percent but not more than 25 percent of the proceeds of the action or settlement of the claim, depending upon the extent to which the person substantially contributed to the prosecution of the action. Where the action is one which the court finds to be based primarily on disclosures of specific information (other than information provided by the person bringing the action) relating to allegations or transactions in a criminal, civil, or administrative hearing, in a congressional, administrative, or Government 1 Accounting Office report, hearing, audit, or investigation, or from the news media, the court may award such sums as it considers appropriate, but in no case more than 10 percent of the proceeds, taking into account the significance of the information and the role of the person bringing the action in advancing the case to litigation. Any payment to a person under the first or second sentence of this paragraph shall be made from the proceeds. Any such person shall also receive an amount for reasonable expenses which the court finds to have been necessarily incurred, plus reasonable attorneys' fees and costs. All such expenses, fees, and costs shall be awarded against the defendant.

(2) If the Government does not proceed with an action under this section, the person bringing the action or settling the claim shall receive an amount which the court decides is reasonable for collecting the civil penalty and damages. The amount shall be not less than 25 percent and not more than 30 percent of the proceeds of the action or settlement and shall be paid out of such proceeds. Such person shall also receive an amount for reasonable expenses which the court finds to have been necessarily incurred, plus reasonable attorneys' fees and costs. All such expenses, fees, and costs shall be awarded against the defendant.

(3) Whether or not the Government proceeds with the action, if the court finds that the action was brought by a person who planned and initiated the violation of section 3729 upon which the action was brought, then the court may, to the extent the court considers appropriate, reduce the share of the proceeds of the action which the person would otherwise receive under paragraph (1) or (2) of this subsection, taking into account the role of that person in advancing the case to litigation and any relevant circumstances pertaining to the violation. If the person bringing the action is convicted of criminal conduct arising from his or her role in the violation of section 3729, that person shall be dismissed from the civil action and shall not receive any share of the proceeds of the action. Such dismissal shall not prejudice the right of the United States to continue the action, represented by the Department of Justice.

(4) If the Government does not proceed with the action and the person bringing the action conducts the action, the court may award to the defendant its reasonable attorneys' fees and expenses if the defendant prevails in the action and the court finds that the claim of the person bringing the action was clearly frivolous, clearly vexatious, or brought primarily for purposes of harassment.

(e) CERTAIN ACTIONS BARRED.—

(1) No court shall have jurisdiction over an action brought by a former or present member of the armed forces under subsection (b) of this section against a member of the armed forces arising out of such person's service in the armed forces.

(2)(A) No court shall have jurisdiction over an action brought under subsection (b) against a Member of Congress, a member of the judiciary, or a senior executive branch official if the action is based on evidence or information known to the Government when the action was brought.

(B) For purposes of this paragraph, ''senior executive branch official'' means any officer or employee listed in paragraphs (1) through (8) of section 101(f) of the Ethics in Government Act of 1978 (5 U.S.C. App.).

(3) In no event may a person bring an action under subsection (b) which is based upon allegations or transactions which are the subject of a civil suit or an administrative civil money penalty proceeding in which the Government is already a party.

(4)(A) No court shall have jurisdiction over an action under this section based upon the public disclosure of allegations or transactions in a criminal, civil, or administrative hearing, in a congressional, administrative, or Government Accounting Office report, hearing, audit, or investigation, or from the news media, unless the action is brought by the Attorney General or the person bringing the action is an original source of the information.

(B) For purposes of this paragraph, ''original source'' means an individual who has direct and independent knowledge of the information on which the allegations are based and has voluntarily provided the information to the Government before filing an action under this section which is based on the information.

(f) GOVERNMENT NOT LIABLE FOR CERTAIN EXPENSES.— The Government is not liable for expenses which a person incurs in bringing an action under this section.

(g) FEES AND EXPENSES TO PREVAILING DEFENDANT.— In civil actions brought under this section by the United States, the provisions of section 2412(d) of title 28 shall apply.

(h) Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of the employee or others in furtherance of an action under this section, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under this section, shall be entitled to all relief necessary to make the employee whole. Such relief shall include reinstatement with the same seniority status such employee would have had but for the discrimination, 2 times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees. An employee may bring an action in the appropriate district court of the United States for the relief provided in this subsection.

§ 3731. False claims procedure

(a) A subpoena requiring the attendance of a witness at a trial or hearing conducted under section 3730 of this title may be served at any place in the United States.

(b) A civil action under section 3730 may not be brought—

(1) more than 6 years after the date on which the violation of section 3729 is committed, or

(2) more than 3 years after the date when facts material to the right of action are known or reasonably should have been known by the official of the United States charged with responsibility to act in the circumstances, but in no event more than 10 years after the date on which the violation is committed, whichever occurs last.

(c) In any action brought under section 3730, the United States shall be required to prove all essential elements of the cause of action, including damages, by a preponderance of the evidence.

(d) Notwithstanding any other provision of law, the Federal Rules of Criminal Procedure,

or the Federal Rules of Evidence, a final judgment rendered in favor of the United States in any criminal proceeding charging fraud or false statements, whether upon a verdict after trial or upon a plea of guilty or nolo contendere, shall stop the defendant from denying the essential elements of the offense in any action which involves the same transaction as in the criminal proceeding and which is brought under subsection (a) or (b) of section 3730.

§ 3732. False claims jurisdiction

(a) ACTIONS UNDER SECTION 3730.—Any action under section 3730 may be brought in any judicial district in which the defendant or, in the case of multiple defendants, any one defendant can be found, resides, transacts business, or in which any act proscribed by section 3729 occurred. A summons as required by the Federal Rules of Civil Procedure shall be issued by the appropriate district court and served at any place within or outside the United States.

(b) CLAIMS UNDER STATE LAW.—The district courts shall have jurisdiction over any action brought under the laws of any State for the recovery of funds paid by a State or local government if the action arises from the same transaction or occurrence as an action brought under section 3730.

§ 3733. Civil investigative demands

(a) IN GENERAL.—

(1) ISSUANCE AND SERVICE.—Whenever the Attorney General has reason to believe that any person may be in possession, custody, or control of any documentary material or information relevant to a false claims law investigation, the Attorney General may, before commencing a civil proceeding under section 3730 or other false claims law, issue in writing and cause to be served upon such person, a civil investigative demand requiring such person—

(A) to produce such documentary material for inspection and copying,

(B) to answer in writing written interrogatories with respect to such documentary material or information,

(C) to give oral testimony concerning such documentary material or information, or

(D) to furnish any combination of such material, answers, or testimony.

The Attorney General may not delegate the authority to issue civil investigative demands under this subsection. Whenever a civil investigative demand is an express demand for any product of discovery, the Attorney General, the Deputy Attorney General, or an Assistant Attorney General shall cause to be served, in any manner authorized by this section, a copy of such demand upon the person from whom the discovery was obtained and shall notify the person to whom such demand is issued of the date on which such copy was served.

(2) CONTENTS AND DEADLINES.—

(A) Each civil investigative demand issued under paragraph (1) shall state the nature of the conduct constituting the alleged violation of a false claims law which is under investigation, and the applicable provision of law alleged to be violated.

(B) If such demand is for the production of documentary material, the demand shall—

(i) describe each class of documentary material to be produced with such definiteness and certainty as to permit such material to be fairly identified;

(ii) prescribe a return date for each such class which will provide a reasonable period of time within which the material so demanded may be assembled and made available for inspection and copying; and

(iii) identify the false claims law investigator to whom such material shall be made available.

(C) If such demand is for answers to written interrogatories, the demand shall—

(i) set forth with specificity the written interrogatories to be answered;

(ii) prescribe dates at which time answers to written interrogatories shall be submitted; and

(iii) identify the false claims law investigator to whom such answers shall be submitted.

(D) If such demand is for the giving of oral testimony, the demand shall—

(i) prescribe a date, time, and place at which oral testimony shall be commenced;

(ii) identify a false claims law investigator who shall conduct the examination and the custodian to whom the transcript of such examination shall be submitted;

(iii) specify that such attendance and testimony are necessary to the conduct of the investigation;

(iv) notify the person receiving the demand of the right to be accompanied by an attorney and any other representative; and

(v) describe the general purpose for which the demand is being issued and the general nature of the testimony, including the primary areas of inquiry, which will be taken pursuant to the demand.

(E) Any civil investigative demand issued under this section which is an express demand for any product of discovery shall not be returned or returnable until 20 days after a copy of such demand has been served upon the person from whom the discovery was obtained.

(F) The date prescribed for the commencement of oral testimony pursuant to a civil investigative demand issued under this section shall be a date which is not less than seven days after the date on which demand is received, unless the Attorney General or an Assistant Attorney General designated by the Attorney General determines that exceptional circumstances are present which warrant the commencement of such testimony within a lesser period of time.

(G) The Attorney General shall not authorize the issuance under this section of more than one civil investigative demand for oral testimony by the same person unless the person requests otherwise or unless the Attorney General, after investigation, notifies that person in writing that an additional demand for oral testimony is necessary. The Attorney General may not, notwithstanding section 510 of title 28, authorize the performance, by any other officer, employee, or agency, of any function vested in the Attorney General under this subparagraph.

(b) PROTECTED MATERIAL OR INFORMATION.—

(1) IN GENERAL.—A civil investigative demand issued under subsection (a) may not require the production of any documentary material, the submission of any answers to written interrogatories, or the giving of any oral testimony if such material, answers, or testimony would be protected from disclosure under—

(A) the standards applicable to subpoenas or subpoenas duces tecum issued by a court of the United States to aid in a grand jury investigation; or

(B) the standards applicable to discovery requests under the Federal Rules of Civil Procedure, to the extent that the application of such standards to any such demand is appropriate and consistent with the provisions and purposes of this section.

(2) EFFECT ON OTHER ORDERS, RULES, AND LAWS.—Any such demand which is an express demand for any product of discovery supersedes any inconsistent order, rule, or provision of law (other than this section) preventing or restraining disclosure of such product of discovery to

any person. Disclosure of any product of discovery pursuant to any such express demand does not constitute a waiver of any right or privilege which the person making such disclosure may be entitled to invoke to resist discovery of trial preparation materials.

(c) SERVICE; JURISDICTION.—

(1) BY WHOM SERVED.—Any civil investigative demand issued under subsection (a) may be served by a false claims law investigator, or by a United States marshal or a deputy marshal, at any place within the territorial jurisdiction of any court of the United States.

(2) SERVICE IN FOREIGN COUNTRIES.—Any such demand or any petition filed under subsection (j) may be served upon any person who is not found within the territorial jurisdiction of any court of the United States in such manner as the Federal Rules of Civil Procedure prescribe for service in a foreign country. To the extent that the courts of the United States can assert jurisdiction over any such person consistent with due process, the United States District Court for the District of Columbia shall have the same jurisdiction to take any action respecting compliance with this section by any such person that such court would have if such person were personally within the jurisdiction of such court.

(d) SERVICE UPON LEGAL ENTITIES AND NATURAL PERSONS.—

(1) LEGAL ENTITIES.—Service of any civil investigative demand issued under subsection (a) or of any petition filed under subsection (j) may be made upon a partnership, corporation, association, or other legal entity by—

(A) delivering an executed copy of such demand or petition to any partner, executive officer, managing agent, or general agent of the partnership, corporation, association, or entity, or to any agent authorized by appointment or by law to receive service of process on behalf of such partnership, corporation, association, or entity;

(B) delivering an executed copy of such demand or petition to the principal office or place of business of the partnership, corporation, association, or entity; or

(C) depositing an executed copy of such demand or petition in the United States mails by registered or certified mail, with a return receipt requested, addressed to such partnership, corporation, association, or entity at its principal office or place of business.

(2) NATURAL PERSONS.—Service of any such demand or petition may be made upon any natural person by—

(A) delivering an executed copy of such demand or petition to the person; or

(B) depositing an executed copy of such demand or petition in the United States mails by registered or certified mail, with a return receipt requested, addressed to the person at the person's residence or principal office or place of business.

(e) PROOF OF SERVICE.—A verified return by the individual serving any civil investigative demand issued under subsection (a) or any petition filed under subsection (j) setting forth the manner of such service shall be proof of such service. In the case of service by registered or certified mail, such return shall be accompanied by the return post office receipt of delivery of such demand.

(f) DOCUMENTARY MATERIAL.—

(1) SWORN CERTIFICATES.—The production of documentary material in response to a civil investigative demand served under this section shall be made under a sworn certificate, in such form as the demand designates, by—

(A) in the case of a natural person, the person to whom the demand is directed, or

(B) in the case of a person other than a natural person, a person having knowledge of the facts and circumstances relating to such production and authorized to act on behalf of such person.

The certificate shall state that all of the documentary material required by the demand and in the possession, custody, or control of the person to whom the demand is directed has been produced and made available to the false claims law investigator identified in the demand.

(2) PRODUCTION OF MATERIALS.—Any person upon whom any civil investigative demand for the production of documentary material has been served under this section shall make such material available for inspection and copying to the false claims law investigator identified in such demand at the principal place of business of such person, or at such other place as the false claims law investigator and the person thereafter may agree and prescribe in writing, or as the court may direct under subsection (j)(1). Such material shall be made so available on the return date specified in such demand, or on such later date as the false claims law investigator may prescribe in writing. Such person may, upon written agreement between the person and the false claims law investigator, substitute copies for originals of all or any part of such material.

(g) INTERROGATORIES.—Each interrogatory in a civil investigative demand served under this section shall be answered separately and fully in writing under oath and shall be submitted under a sworn certificate, in such form as the demand designates, by—

(1) in the case of a natural person, the person to whom the demand is directed, or

(2) in the case of a person other than a natural person, the person or persons responsible for answering each interrogatory.

If any interrogatory is objected to, the reasons for the objection shall be stated in the certificate instead of an answer. The certificate shall state that all information required by the demand and in the possession, custody, control, or knowledge of the person to whom the demand is directed has been submitted. To the extent that any information is not furnished, the information shall be identified and reasons set forth with particularity regarding the reasons why the information was not furnished.

(h) ORAL EXAMINATIONS.—

(1) PROCEDURES.—The examination of any person pursuant to a civil investigative demand for oral testimony served under this section shall be taken before an officer authorized to administer oaths and affirmations by the laws of the United States or of the place where the examination is held. The officer before whom the testimony is to be taken shall put the witness on oath or affirmation and shall, personally or by someone acting under the direction of the officer and in the officer's presence, record the testimony of the witness. The testimony shall be taken stenographically and shall be transcribed. When the testimony is fully transcribed, the officer before whom the testimony is taken shall promptly transmit a copy of the transcript of the testimony to the custodian. This subsection shall not preclude the taking of testimony by any means authorized by, and in a manner consistent with, the Federal Rules of Civil Procedure.

(2) PERSONS PRESENT.—The false claims law investigator conducting the examination shall exclude from the place where the examination is held all persons except the person giving the testimony, the attorney for and any other representative of the person giving the testimony, the attorney for the Government, any person who may be agreed upon by the attorney for the Government and the person giving the testimony, the officer before whom the testimony is to be taken, and any stenographer taking such testimony.

(3) WHERE TESTIMONY TAKEN.—The oral testimony of any person taken pursuant to a civil investigative demand served under this section shall be taken in the judicial district of the United States within which such person resides, is found, or transacts business, or in such other place as

may be agreed upon by the false claims law investigator conducting the examination and such person.

(4) TRANSCRIPT OF TESTIMONY.— When the testimony is fully transcribed, the false claims law investigator or the officer before whom the testimony is taken shall afford the witness, who may be accompanied by counsel, a reasonable opportunity to examine and read the transcript, unless such examination and reading are waived by the witness. Any changes in form or substance which the witness desires to make shall be entered and identified upon the transcript by the officer or the false claims law investigator, with a statement of the reasons given by the witness for making such changes. The transcript shall then be signed by the witness, unless the witness in writing waives the signing, is ill, cannot be found, or refuses to sign. If the transcript is not signed by the witness within 30 days after being afforded a reasonable opportunity to examine it, the officer or the false claims law investigator shall sign it and state on the record the fact of the waiver, illness, absence of the witness, or the refusal to sign, together with the reasons, if any, given therefor.

(5) CERTIFICATION AND DELIVERY TO CUSTODIAN.— The officer before whom the testimony is taken shall certify on the transcript that the witness was sworn by the officer and that the transcript is a true record of the testimony given by the witness, and the officer or false claims law investigator shall promptly deliver the transcript, or send the transcript by registered or certified mail, to the custodian.

(6) FURNISHING OR INSPECTION OF TRANSCRIPT BY WITNESS.—Upon payment of reasonable charges therefor, the false claims law investigator shall furnish a copy of the transcript to the witness only, except that the Attorney General, the Deputy Attorney General, or an Assistant Attorney General may, for good cause, limit such witness to inspection of the official transcript of the witness' testimony.

(7) CONDUCT OF ORAL TESTIMONY.—

(A) Any person compelled to appear for oral testimony under a civil investigative demand issued under subsection (a) may be accompanied, represented, and advised by counsel. Counsel may advise such person, in confidence, with respect to any question asked of such person. Such person or counsel may object on the record to any question, in whole or in part, and shall briefly state for the record the reason for the objection. An objection may be made, received, and entered upon the record when it is claimed that such person is entitled to refuse to answer the question on the grounds of any constitutional or other legal right or privilege, including the privilege against self-incrimination. Such person may not otherwise object to or refuse to answer any question, and may not directly or through counsel otherwise interrupt the oral examination. If such person refuses to answer any question, a petition may be filed in the district court of the United States under subsection (j)(1) for an order compelling such person to answer such question.

(B) If such person refuses to answer any question on the grounds of the privilege against self-incrimination, the testimony of such person may be compelled in accordance with the provisions of part V of title 18.

(8) WITNESS FEES AND ALLOWANCES.—Any person appearing for oral testimony under a civil investigative demand issued under subsection (a) shall be entitled to the same fees and allowances which are paid to witnesses in the district courts of the United States.

(i) CUSTODIANS OF DOCUMENTS, ANSWERS, AND TRANSCRIPTS.—

(1) DESIGNATION.—The Attorney General shall designate a false claims law investigator to serve as custodian of documentary material, answers to interrogatories, and transcripts of oral testimony received under this section, and shall designate such additional false claims law investigators as the Attorney General determines from time to time to be necessary to serve as deputies to the custodian.

(2) RESPONSIBILITY FOR MATERIALS; DISCLOSURE.—

(A) A false claims law investigator who receives any documentary material, answers to interrogatories, or transcripts of oral testimony under this section shall transmit them to the custodian. The custodian shall take physical possession of such material, answers, or transcripts and shall be responsible for the use made of them and for the return of documentary material under paragraph (4).

(B) The custodian may cause the preparation of such copies of such documentary material, answers to interrogatories, or transcripts of oral testimony as may be required for official use by any false claims law investigator, or other officer or employee of the Department of Justice, who is authorized for such use under regulations which the Attorney General shall issue. Such material, answers, and transcripts may be used by any such authorized false claims law investigator or other officer or employee in connection with the taking of oral testimony under this section.

(C) Except as otherwise provided in this subsection, no documentary material, answers to interrogatories, or transcripts of oral testimony, or copies thereof, while in the possession of the custodian, shall be available for examination by any individual other than a false claims law investigator or other officer or employee of the Department of Justice authorized under subparagraph (B). The prohibition in the preceding sentence on the availability of material, answers, or transcripts shall not apply if consent is given by the person who produced such material, answers, or transcripts, or, in the case of any product of discovery produced pursuant to an express demand for such material, consent is given by the person from whom the discovery was obtained. Nothing in this subparagraph is intended to prevent disclosure to the Congress, including any committee or subcommittee of the Congress, or to any other agency of the United States for use by such agency in furtherance of its statutory responsibilities. Disclosure of information to any such other agency shall be allowed only upon application, made by the Attorney General to a United States district court, showing substantial need for the use of the information by such agency in furtherance of its statutory responsibilities.

(D) While in the possession of the custodian and under such reasonable terms and conditions as the Attorney General shall prescribe—

(i) documentary material and answers to interrogatories shall be available for examination by the person who produced such material or answers, or by a representative of that person authorized by that person to examine such material and answers; and

(ii) transcripts of oral testimony shall be available for examination by the person who produced such testimony, or by a representative of that person authorized by that person to examine such transcripts.

(3) USE OF MATERIAL, ANSWERS, OR TRANSCRIPTS IN OTHER PROCEEDINGS.—Whenever any attorney of the Department of Justice has been designated to appear before any court, grand jury, or Federal agency in any case or proceeding, the custodian of any documentary material, answers to interrogatories, or transcripts of oral testimony received under this section may

deliver to such attorney such material, answers, or transcripts for official use in connection with any such case or proceeding as such attorney determines to be required. Upon the completion of any such case or proceeding, such attorney shall return to the custodian any such material, answers, or transcripts so delivered which have not passed into the control of such court, grand jury, or agency through introduction into the record of such case or proceeding.

(4) CONDITIONS FOR RETURN OF MATERIAL.—If any documentary material has been produced by any person in the course of any false claims law investigation pursuant to a civil investigative demand under this section, and—

(A) any case or proceeding before the court or grand jury arising out of such investigation, or any proceeding before any Federal agency involving such material, has been completed, or

(B) no case or proceeding in which such material may be used has been commenced within a reasonable time after completion of the examination and analysis of all documentary material and other information assembled in the course of such investigation,

the custodian shall, upon written request of the person who produced such material, return to such person any such material (other than copies furnished to the false claims law investigator under subsection (f)(2) or made for the Department of Justice under paragraph (2)(B)) which has not passed into the control of any court, grand jury, or agency through introduction into the record of such case or proceeding.

(5) APPOINTMENT OF SUCCESSOR CUSTODIANS.— In the event of the death, disability, or separation from service in the Department of Justice of the custodian of any documentary material, answers to interrogatories, or transcripts of oral testimony produced pursuant to a civil investigative demand under this section, or in the event of the official relief of such custodian from responsibility for the custody and control of such material, answers, or transcripts, the Attorney General shall promptly—

(A) designate another false claims law investigator to serve as custodian of such material, answers, or transcripts, and

(B) transmit in writing to the person who produced such material, answers, or testimony notice of the identity and address of the successor so designated.

Any person who is designated to be a successor under this paragraph shall have, with regard to such material, answers, or transcripts, the same duties and responsibilities as were imposed by this section upon that person's predecessor in office, except that the successor shall not be held responsible for any default or dereliction which occurred before that designation.

(j) JUDICIAL PROCEEDINGS.—

(1) PETITION FOR ENFORCEMENT.— Whenever any person fails to comply with any civil investigative demand issued under subsection (a), or whenever satisfactory copying or reproduction of any material requested in such demand cannot be done and such person refuses to surrender such material, the Attorney General may file, in the district court of the United States for any judicial district in which such person resides, is found, or transacts business, and serve upon such person a petition for an order of such court for the enforcement of the civil investigative demand.

(2) PETITION TO MODIFY OR SET ASIDE DEMAND.—

(A) Any person who has received a civil investigative demand issued under subsection (a) may file, in the district court of the United States for the judicial district within which such person resides, is found, or transacts business, and serve upon the false claims law investigator identified in such demand a petition for an order of the court to modify or set aside such demand. In the case of a petition addressed to an express demand for any product of discovery, a petition to modify or set aside such demand may be brought only in the district court of the United States for the judicial district in which the proceeding in which such discovery was obtained is or was last pending. Any petition under this subparagraph must be filed—

(i) within 20 days after the date of service of the civil investigative demand, or at any time before the return date specified in the demand, whichever date is earlier, or

(ii) within such longer period as may be prescribed in writing by any false claims law investigator identified in the demand.

(B) The petition shall specify each ground upon which the petitioner relies in seeking relief under subparagraph (A), and may be based upon any failure of the demand to comply with the provisions of this section or upon any constitutional or other legal right or privilege of such person. During the pendency of the petition in the court, the court may stay, as it deems proper, the running of the time allowed for compliance with the demand, in whole or in part, except that the person filing the petition shall comply with any portions of the demand not sought to be modified or set aside.

(3) PETITION TO MODIFY OR SET ASIDE DEMAND FOR PRODUCT OF DISCOVERY.—

(A) In the case of any civil investigative demand issued under subsection (a) which is an express demand for any product of discovery, the person from whom such discovery was obtained may file, in the district court of the United States for the judicial district in which the proceeding in which such discovery was obtained is or was last pending, and serve upon any false claims law investigator identified in the demand and upon the recipient of the demand, a petition for an order of such court to modify or set aside those portions of the demand requiring production of any such product of discovery. Any petition under this subparagraph must be filed—

(i) within 20 days after the date of service of the civil investigative demand, or at any time before the return date specified in the demand, whichever date is earlier, or

(ii) within such longer period as may be prescribed in writing by any false claims law investigator identified in the demand.

(B) The petition shall specify each ground upon which the petitioner relies in seeking relief under subparagraph (A), and may be based upon any failure of the portions of the demand from which relief is sought to comply with the provisions of this section, or upon any constitutional or other legal right or privilege of the petitioner. During the pendency of the petition, the court may stay, as it deems proper, compliance with the demand and the running of the time allowed for compliance with the demand.

(4) PETITION TO REQUIRE PERFORMANCE BY CUSTODIAN OF DUTIES.— At any time during which any custodian is in custody or control of any documentary material or answers to interrogatories produced, or transcripts of oral testimony given, by any person in compliance with any civil investigative demand issued under subsection (a), such person, and in the case of an express demand for any product of discovery, the person from whom such discovery was obtained, may file, in the district court of the United States for the judicial district within which the office of such custodian is situated, and serve upon such custodian, a petition for an order of such court to require the performance by the custodian of any duty imposed upon the

custodian by this section.

(5) JURISDICTION.—Whenever any petition is filed in any district court of the United States under this subsection, such court shall have jurisdiction to hear and determine the matter so presented, and to enter such order or orders as may be required to carry out the provisions of this section. Any final order so entered shall be subject to appeal under section 1291 of title 28. Any disobedience of any final order entered under this section by any court shall be punished as a contempt of the court.

(6) APPLICABILITY OF FEDERAL RULES OF CIVIL PROCEDURE.—The Federal Rules of Civil Procedure shall apply to any petition under this subsection, to the extent that such rules are not inconsistent with the provisions of this section.

(k) DISCLOSURE EXEMPTION.—Any documentary material, answers to written interrogatories, or oral testimony provided under any civil investigative demand issued under subsection (a) shall be exempt from disclosure under section 552 of title 5.

(*l*) DEFINITIONS.—For purposes of this section—

(1) the term ''*false claims law*'' means—

(A) this section and sections 3729 through 3732; and

(B) any Act of Congress enacted after the date of the enactment of this section which prohibits, or makes available to the United States in any court of the United States any civil remedy with respect to, any false claim against, bribery of, or corruption of any officer or employee of the United States;

(2) the term ''*false claims law investigation*'' means any inquiry conducted by any false claims law investigator for the purpose of ascertaining whether any person is or has been engaged in any violation of a false claims law;

(3) the term ''*false claims law investigator*'' means any attorney or investigator employed by the Department of Justice who is charged with the duty of enforcing or carrying into effect any false claims law, or any officer or employee of the United States acting under the direction and supervision of such attorney or investigator in connection with a false claims law investigation;

(4) the term ''*person*'' means any natural person, partnership, corporation, association, or other legal entity, including any State or political subdivision of a State;

(5) the term ''*documentary material*'' includes the original or any copy of any book, record, report, memorandum, paper, communication, tabulation, chart, or other document, or data compilations stored in or accessible through computer or other information retrieval systems, together with instructions and all other materials necessary to use or interpret such data compilations, and any product of discovery;

(6) the term ''*custodian*'' means the custodian, or any deputy custodian, designated by the Attorney General under subsection (i)(1); and

(7) the term ''*product of discovery*'' includes—

(A) the original or duplicate of any deposition, interrogatory, document, thing, result of the inspection of land or other property, examination, or admission, which is obtained by any method of discovery in any judicial or administrative proceeding of an adversarial nature;

(B) any digest, analysis, selection, compilation, or derivation of any item listed in subparagraph (A); and

(C) any index or other manner of access to any item listed in subparagraph (A).

Administrative Remedies for False Claims and Statements

I. KCMHP and its providers shall comply with the provisions of the federal Administrative Remedies for False Claims and Statements as established under title 31 United States Code chapter 38 as detailed below.

CHAPTER 38—ADMINISTRATIVE REMEDIES FOR FALSE CLAIMS AND STATEMENTS

Sec.
3801. Definitions.
3802. False claims and statements; liability.
3803. Hearing and determinations.
3804. Subpoena authority.
3805. Judicial review.
3806. Collection of civil penalties and assessments.
3807. Right to administrative offset.
3808. Limitations.
3809. Regulations.
[3810. Repealed.]
3811. Effect on other law.
3812. Prohibition against delegation.

§ 3801. Definitions

(a) For purposes of this chapter—

(1) ''*authority*'' means—

(A) an executive department;

(B) a military department;

(C) an establishment (as such term is defined in section 11(2) of the Inspector General Act of 1978) which is not an executive department; and

(D) the United States Postal Service;

(2) ''*authority head*'' means—

(A) the head of an authority; or

(B) an official or employee of the authority designated, in regulations promulgated by the head of the authority, to act on behalf of the head of the authority;

(3) ''*claim*'' means any request, demand, or submission—

(A) made to an authority for property, services, or money (including money representing grants, loans, insurance, or benefits);

(B) made to a recipient of property, services, or money from an authority or to a party to a contract with an authority—

(i) for property or services if the United States—

(I) provided such property or services;

(II) provided any portion of the funds for the purchase of such property or services; or

(III) will reimburse such recipient or party for the purchase of such property or services; or

(ii) for the payment of money (including money representing grants, loans, insurance, or benefits) if the United States—

(I) provided any portion of the money requested or demanded; or

(II) will reimburse such recipient or party for any portion of the money paid on such request or demand; or

(C) made to an authority which has the effect of decreasing an obligation to pay or account for property, services, or money, except that such term does not include any claim made in any return of tax imposed by the Internal Revenue Code of 1986;

(4) ''*investigating official*'' means an individual who—

(A)(i) in the case of an authority in which an Office of Inspector General is established by the Inspector General Act of 1978 or by any other Federal law, is the Inspector General of that authority or an officer or employee of such Office designated by the Inspector General;

(ii) in the case of an authority in which an Office of Inspector General is not established by the Inspector General Act of 1978 or by any other Federal law, is an officer or employee of the authority designated by the authority head to conduct investigations under section 3803(a)(1) of this title; or

(iii) in the case of a military department, is the Inspector General of the Department of Defense or an officer or employee of the Office of Inspector General of the Department of Defense who is designated by the Inspector General; and

(B) who, if a member of the Armed Forces of the United States on active duty, is serving in grade O–7 or above or, if a civilian employee, is serving in a position for which the rate of basic pay is not less than the minimum rate of basic pay for grade GS–16 under the General Schedule;

(5) ''*knows or has reason to know*'', for purposes of establishing liability under section 3802, means that a person, with respect to a claim or statement—

(A) has actual knowledge that the claim or statement is false, fictitious, or fraudulent;

(B) acts in deliberate ignorance of the truth or falsity of the claim or statement; or

(C) acts in reckless disregard of the truth or falsity of the claim or statement, and no proof of specific intent to defraud is required;

(6) ''*person*'' means any individual, partnership, corporation, association, or private organization;

(7) ''*presiding officer*'' means—

(A) in the case of an authority to which the provisions of subchapter II of chapter 5 of title 5 apply, an administrative law judge appointed in the authority pursuant to section 3105 of such title or detailed to the authority pursuant to section 3344 of such title; or

(B) in the case of an authority to which the provisions of such subchapter do not apply, an officer or employee of the authority who—

(i) is selected under chapter 33 of title 5 pursuant to the competitive examination process applicable to administrative law judges;

(ii) is appointed by the authority head to conduct hearings under section 3803 of this title;

(iii) is assigned to cases in rotation so far as practicable;

(iv) may not perform duties inconsistent with the duties and responsibilities of a presiding officer;

(v) is entitled to pay prescribed by the Office of Personnel Management independently of ratings and recommendations made by the authority and in accordance with chapter 51 of such title and subchapter III of chapter 53 of such title;

(vi) is not subject to performance appraisal pursuant to chapter 43 of such title; and

(vii) may be removed, suspended, furloughed, or reduced in grade or pay only for good cause established and determined by the Merit Systems Protection Board on the record after opportunity for hearing by such Board;

(8) ''*reviewing official*'' means any officer or employee of an authority—

(A) who is designated by the authority head to make the determination required under section 3803(a)(2) of this title;

(B) who, if a member of the Armed Forces of the United States on active duty, is serving in grade O–7 or above or, if a civilian employee, is serving in a position for which the rate of basic pay is not less than the minimum rate of basic pay for grade GS–16 under the General Schedule; and

(C) who is—

(i) not subject to supervision by, or

required to report to, the investigating official; and

(ii) not employed in the organizational unit of the authority in which the investigating official is employed; and

(9) ''*statement*'' means any representation, certification, affirmation, document, record, or accounting or bookkeeping entry made—

(A) with respect to a claim or to obtain the approval or payment of a claim (including relating to eligibility to make a claim); or

(B) with respect to (including relating to eligibility for)—

(i) a contract with, or a bid or proposal for a contract with; or

(ii) a grant, loan, or benefit from, an authority, or any State, political subdivision of a State, or other party, if the United States Government provides any portion of the money or property under such contract or for such grant, loan, or benefit, or if the Government will reimburse such State, political subdivision, or party for any portion of the money or property under such contract or for such grant, loan, or benefit,

except that such term does not include any statement made in any return of tax imposed by the Internal Revenue Code of 1986.

(b) For purposes of paragraph (3) of subsection (a)—

(1) each voucher, invoice, claim form, or other individual request or demand for property, services, or money constitutes a separate claim;

(2) each claim for property, services, or money is subject to this chapter regardless of whether such property, services, or money is actually delivered or paid; and

(3) a claim shall be considered made, presented, or submitted to an authority, recipient, or party when such claim is actually made to an agent, fiscal intermediary, or other entity, including any State or political subdivision thereof, acting for or on behalf of such authority, recipient, or party.

(c) For purposes of paragraph (9) of subsection (a)—

(1) each written representation, certification, or affirmation constitutes a separate statement; and

(2) a statement shall be considered made, presented, or submitted to an authority when such statement is actually made to an agent, fiscal intermediary, or other entity, including any State or political subdivision thereof, acting for or on behalf of such authority.

§ 3802. False claims and statements; liability

(a)(1) Any person who makes, presents, or submits, or causes to be made, presented, or sub mitted, a claim that the person knows or has reason to know—

(A) is false, fictitious, or fraudulent;

(B) includes or is supported by any written statement which asserts a material fact which is false, fictitious, or fraudulent;

(C) includes or is supported by any written statement that—

(i) omits a material fact;

(ii) is false, fictitious, or fraudulent as a result of such omission; and

(iii) is a statement in which the person making, presenting, or submitting such statement has a duty to include such material fact; or

(D) is for payment for the provision of property or services which the person has not provided as claimed,

shall be subject to, in addition to any other remedy that may be prescribed by law, a civil penalty of not more than **$5,000** for each such claim. Except as provided in paragraph (3) of this subsection, such person shall also be subject to an assessment, in lieu of damages sustained by the United States because of such claim, of not more than twice the amount of such claim, or the portion of such claim, which is determined under this chapter to be in violation of the preceding sentence.

(2) Any person who makes, presents, or submits, or causes to be made, presented, or submitted, a written statement that—

(A) the person knows or has reason to know—

(i) asserts a material fact which is false, fictitious, or fraudulent; or

(ii)(I) omits a material fact; and

(II) is false, fictitious, or fraudulent as a result of such omission;

(B) in the case of a statement described in clause (ii) of subparagraph (A), is a statement in which the person making, presenting, or submitting such statement has a duty to include such material fact; and

(C) contains or is accompanied by an express certification or affirmation of the truthfulness and accuracy of the contents of the statement,

shall be subject to, in addition to any other remedy that may be prescribed by law, a civil penalty of not more than **$5,000** for each such statement.

(3) An assessment shall not be made under the second sentence of paragraph (1) with respect to a claim if payment by the Government has not been made on such claim.

(b)(1) Except as provided in paragraphs (2) and (3) of this subsection—

(A) a determination under section 3803(a)(2) of this title that there is adequate evidence to believe that a person is liable under subsection (a) of this section; or

(B) a determination under section 3803 of this title that a person is liable under subsection (a) of this section,

may provide the authority with grounds for commencing any administrative or contractual action against such person which is authorized by law and which is in addition to any action against such person under this chapter.

(2) A determination referred to in paragraph (1) of this subsection may be used by the authority, but shall not require such authority, to commence any administrative or contractual action which is authorized by law.

(3) In the case of an administrative or contractual action to suspend or debar any person who is eligible to enter into contracts with the Federal Government, a determination referred to in paragraph (1) of this subsection shall not be considered as a conclusive determination of such person's responsibility pursuant to Federal procurement laws and regulations.

§ 3803. Hearing and determinations

(a)(1) The investigating official of an authority may investigate allegations that a person is liable under section 3802 of this title and shall report the findings and conclusions of such investigation to the reviewing official of the authority. The preceding sentence does not modify any responsibility of an investigating official to report violations of criminal law to the Attorney General.

(2) If the reviewing official of an authority determines, based upon the report of the investigating official under paragraph (1) of this subsection, that there is adequate evidence to believe that a person is liable under section 3802 of this title, the reviewing official shall transmit to the Attorney General a written notice of the intention of such official to refer the allegations of such liability to a presiding officer of such authority. Such notice shall include—

(A) a statement of the reasons of the reviewing official for the referral of such allegations;

(B) a statement specifying the evidence which supports such allegations;

(C) a description of the claims or statements for which liability under section 3802 of this title is alleged;

(D) an estimate of the amount of money

or the value of property or services requested or demanded in violation of section 3802 of this title; and

(E) a statement of any exculpatory or mitigating circumstances which may relate to such claims or statements.

(b)(1) Within 90 days after receipt of a notice from a reviewing official under paragraph (2) of subsection (a), the Attorney General or an Assistant Attorney General designated by the Attorney General shall transmit a written statement to the reviewing official which specifies—

(A) that the Attorney General or such Assistant Attorney General approves or disapproves the referral to a presiding officer of the allegations of liability stated in such notice;

(B) in any case in which the referral of allegations is approved, that the initiation of a proceeding under this section with respect to such allegations is appropriate; and

(C) in any case in which the referral of allegations is disapproved, the reasons for such disapproval.

(2) A reviewing official may refer allegations of liability to a presiding officer only if the Attorney General or an Assistant Attorney General designated by the Attorney General approves the referral of such allegations in a written statement described in paragraph (1) of this subsection.

(3) If the Attorney General or an Assistant Attorney General designated by the Attorney General transmits to an authority head a written finding that the continuation of any hearing under this section with respect to a claim or statement may adversely affect any pending or potential criminal or civil action related to such claim or statement, such hearing shall be immediately stayed and may be resumed only upon written authorization of the Attorney General.

(c)(1) No allegations of liability under section 3802 of this title with respect to any claim made, presented, or submitted by any person shall be referred to a presiding officer under paragraph (2) of subsection (b) if the reviewing official determines that—

(A) an amount of money in excess of $150,000; or

(B) property or services with a value in excess of $150,000,

is requested or demanded in violation of section 3802 of this title in such claim or in a group of related claims which are submitted at the time such claim is submitted.

(2)(A) Except as provided in subparagraph (B) of this paragraph, no allegations of liability against an individual under section 3802 of this title with respect to any claim or statement made, presented, or submitted, or caused to be made, presented, or submitted, by such individual relating to any benefits received by such individual shall be referred to a presiding officer under paragraph (2) of subsection (b).

(B) Allegations of liability against an individual under section 3802 of this title with respect to any claim or statement made, presented, or submitted, or caused to be made, presented, or submitted, by such individual relating to any benefits received by such individual may be referred to a presiding officer under paragraph (2) of subsection (b) if—

(i) such claim or statement is made by such individual in making application for such benefits;

(ii) such allegations relate to the eligibility of such individual to receive such benefits; and

(iii) with respect to such claim or statement, the individual—

(I) has actual knowledge that the claim or statement is false, fictitious, or fraudulent;

(II) acts in deliberate ignorance of the truth or falsity of the claim or statement; or

(III) acts in reckless disregard of the truth or falsity of the claim or statement.

(C) For purposes of this subsection, the term ''benefits'' means—

(i) benefits under the supplemental security income program under title XVI of the Social Security Act;

(ii) old age, survivors, and disability insurance benefits under title II of the Social Security Act;

(iii) benefits under title XVIII of the Social Security Act;

(iv) assistance under a State program funded under part A of title IV of the Social Security Act;

(v) medical assistance under a State plan approved under section 1902(a) of the Social Security Act;

(vi) benefits under title XX of the Social Security Act;

(vii) benefits under the food stamp program (as defined in section 3(h) of the Food Stamp Act of 1977);

(viii) benefits under chapters 11, 13, 15, 17, and 21 of title 38;

(ix) benefits under the Black Lung Benefits Act;

(x) benefits under the special supplemental nutrition program for women, infants, and children established under section 17 of the Child Nutrition Act of 1966;

(xi) benefits under section 336 of the Older Americans Act;

(xii) any annuity or other benefit under the Railroad Retirement Act of 1974;

(xiii) benefits under the Richard B. Russell National School Lunch Act;

(xiv) benefits under any housing assistance program for lower income families or elderly or handicapped persons which is administered by the Secretary of Housing and Urban Development or the Secretary of Agriculture;

(xv) benefits under the Low-Income Home Energy Assistance Act of 1981; and

(xvi) benefits under part A of the Energy Conservation in Existing Buildings Act of 1976, which are intended for the personal use of the individual who receives the benefits or for a member of the individual's family.

(d)(1) On or after the date on which a reviewing official is permitted to refer allegations of liability to a presiding officer under subsection (b) of this section, the reviewing official shall mail, by registered or certified mail, or shall deliver, a notice to the person alleged to be liable under section 3802 of this title. Such notice shall specify the allegations of liability against such person and shall state the right of such person to request a hearing with respect to such allegations.

(2) If, within 30 days after receiving a notice under paragraph (1) of this subsection, the person receiving such notice requests a hearing with respect to the allegations contained in such notice—

(A) the reviewing official shall refer such allegations to a presiding officer for the commencement of such hearing; and

(B) the presiding officer shall commence such hearing by mailing by registered or certified mail, or by delivery of, a notice which complies with paragraphs (2)(A) and (3)(B)(i) of subsection (g) to such person.

(e)(1)(A) Except as provided in subparagraph (B) of this paragraph, at any time after receiving a notice under paragraph (2)(B) of subsection (d), the person receiving such notice shall be entitled to review, and upon payment of a reasonable fee for duplication, shall be entitled to obtain a copy of, all relevant and material documents, transcripts, records, and other materials, which relate to such allegations and upon which the findings and conclusions of the investigating official

under paragraph (1) of subsection (a) are based.

(B) A person is not entitled under subparagraph (A) to review and obtain a copy of any document, transcript, record, or material which is privileged under Federal law.

(2) At any time after receiving a notice under paragraph (2)(B) of subsection (d), the person receiving such notice shall be entitled to obtain all exculpatory information in the possession of the investigating official or the reviewing official relating to the allegations contained in such notice. The provisions of subparagraph (B) of paragraph (1) do not apply to any document, transcript, record, or other material, or any portion thereof, in which such exculpatory information is contained.

(f) Any hearing commenced under paragraph (2) of subsection (d) shall be conducted by the presiding officer on the record in order to determine—

(1) the liability of a person under section 3802 of this title; and

(2) if a person is determined to be liable under such section, the amount of any civil penalty or assessment to be imposed on such person.

Any such determination shall be based on the preponderance of the evidence.

(g)(1) Each hearing under subsection (f) of this section shall be conducted—

(A) in the case of an authority to which the provisions of subchapter II of chapter 5 of title 5 apply, in accordance with—

(i) the provisions of such subchapter to the extent that such provisions are not inconsistent with the provisions of this chapter; and

(ii) procedures promulgated by the authority head under paragraph (3) of this subsection; or

(B) in the case of an authority to which the provisions of such subchapter do not apply, in accordance with procedures promulgated by the authority head under paragraphs (2) and (3) of this subsection.

(2) An authority head of an authority described in subparagraph (B) of paragraph (1) shall by regulation promulgate procedures for the conduct of hearings under this chapter. Such procedures shall include:

(A) The provision of written notice of the hearing to any person alleged to be liable under section 3802 of this title, including written notice of—

(i) the time, place, and nature of the hearing;

(ii) the legal authority and jurisdiction under which the hearing is to be held; and

(iii) the matters of facts and law to be asserted.

(B) The provision to any person alleged to be liable under section 3802 of this title of opportunities for the submission of facts, arguments, offers of settlement, or proposals of adjustment.

(C) Procedures to ensure that the presiding officer shall not, except to the extent required for the disposition of ex parte matters as authorized by law—

(i) consult a person or party on a fact in issue, unless on notice and opportunity for all parties to the hearing to participate; or

(ii) be responsible to or subject to the supervision or direction of the investigating official or the reviewing official.

(D) Procedures to ensure that the investigating official and the reviewing official do not participate or advise in the decision required under subsection (h) of this section or the review of the decision by the authority head under subsection (i) of this section, except as provided in subsection (j) of this section.

(E) The provision to any person alleged to be liable under section 3802 of this title of opportunities to present such person's case through oral or documentary evidence, to submit rebuttal evidence, and to conduct such cross-examination as may be required for a full and true disclosure of the facts.

(F) Procedures to permit any person alleged to be liable under section 3802 of this title to be accompanied, represented, and advised by counsel or such other qualified representative as the authority head may specify in such regulations.

(G) Procedures to ensure that the hearing is conducted in an impartial manner, including procedures to—

(i) permit the presiding officer to at any time disqualify himself; and

(ii) permit the filing, in good faith, of a timely and sufficient affidavit alleging personal bias or another reason for disqualification of a presiding officer or a reviewing official.

(3)(A) Each authority head shall promulgate by regulation procedures described in subparagraph (B) of this paragraph for the conduct of hearings under this chapter. Such procedures shall be in addition to the procedures described in paragraph (1) or paragraph (2) of this subsection, as the case may be.

(B) The procedures referred to in subparagraph (A) of this paragraph are:

(i) Procedures for the inclusion, in any written notice of a hearing under this section to any person alleged to be liable under section 3802 of this title, of a description of the procedures for the conduct of the hearing.

(ii) Procedures to permit discovery by any person alleged to be liable under section 3802 of this title only to the extent that the presiding officer determines that such discovery is necessary for the expeditious, fair, and reasonable consideration of the issues, except that such procedures shall not apply to documents, transcripts, records, or other material which a person is entitled to review under paragraph (1) of subsection (e) or to information to which a person is entitled under paragraph (2) of such subsection. Procedures promulgated under this clause shall prohibit the discovery of the notice required under subsection (a)(2) of this section.

(4) Each hearing under subsection (f) of this section shall be held—

(A) in the judicial district of the United States in which the person alleged to be liable under section 3802 of this title resides or transacts business;

(B) in the judicial district of the United States in which the claim or statement upon section was made, presented, or submitted; or (C) in such other place as may be agreed upon by such person and the presiding officer who will conduct such hearing.

(h) The presiding officer shall issue a written decision, including findings and determinations, after the conclusion of the hearing. Such decision shall include the findings of fact and conclusions of law which the presiding officer relied upon in determining whether a person is liable under this chapter. The presiding officer shall promptly send to each party to the hearing a copy of such decision and a statement describing the right of any person determined to be liable under section 3802 of this title to appeal the decision of the presiding officer to the authority head under paragraph (2) of subsection (i).

(i)(1) Except as provided in paragraph (2) of this subsection and section 3805 of this title, the decision, including the findings and determinations, of the presiding officer issued under subsection (h) of this section are final.

(2)(A)(i) Except as provided in clause (ii) of this subparagraph, within 30 days after the presiding officer issues a decision under subsection (h) of this section, any person determined in such decision to be liable under section 3802 of this title may appeal such decision to

the authority head.

(ii) If, within the 30-day period described in clause (i) of this subparagraph, a person determined to be liable under this chapter requests the authority head for an extension of such 30-day period to file an appeal of a decision issued by the presiding officer under subsection (h) of this section, the authority head may extend such period if such person demonstrates good cause for such extension.

(B) Any authority head reviewing under this section the decision, findings, and determinations of a presiding officer shall not consider any objection that was not raised in the hearing conducted pursuant to subsection (f) of this section unless a demonstration is made of extraordinary circumstances causing the failure to raise the objection. If any party demonstrates to the satisfaction of the authority head that additional evidence not presented at such hearing is material and that there were reasonable grounds for the failure to present such evidence at such hearing, the authority head shall remand the matter to the presiding officer for consideration of such additional evidence.

(C) The authority head may affirm, reduce, reverse, compromise, remand, or settle any penalty or assessment determined by the presiding officer pursuant to this section. The authority head shall promptly send to each party to the appeal a copy of the decision of the authority head and a statement describing the right of any person determined to be liable under section 3802 of this title to judicial review under section 3805 of this title.

(j) The reviewing official has the exclusive authority to compromise or settle any allegations of liability under section 3802 of this title against a person without the consent of the presiding officer at any time after the date on which the reviewing official is permitted to refer allegations of liability to a presiding officer under subsection (b) of this section and prior to the date on which the presiding officer issues a decision under subsection (h) of this section. Any such compromise or settlement shall be in writing.

§ 3804. Subpoena authority

(a) For the purposes of an investigation under section 3803(a)(1) of this title, an investigating official is authorized to require by subpoena the production of all information, documents, reports, answers, records, accounts, papers, and data not otherwise reasonably available to the authority.

(b) For the purposes of conducting a hearing under section 3803(f) of this title, a presiding officer is authorized—

(1) to administer oaths or affirmations; and

(2) to require by subpoena the attendance and testimony of witnesses and the production of all information, documents, reports, answers, records, accounts, papers, and other data and documentary evidence which the presiding officer considers relevant and material to the hearing.

(c) In the case of contumacy or refusal to obey a subpoena issued pursuant to subsection (a) or (b) of this section, the district courts of the United States shall have jurisdiction to issue an appropriate order for the enforcement of any such subpoena. Any failure to obey such order of the court is punishable by such court as contempt. In any case in which an authority seeks the enforcement of a subpoena issued pursuant to subsection (a) or (b) of this section, the authority shall request the Attorney General to petition any district court in which a hearing under this chapter is being conducted, or in which the person receiving the subpoena resides or conducts business, to issue such an order.

§ 3805. Judicial review

(a)(1) A determination by a reviewing official under section 3803 of this title shall be final and shall not be subject to judicial review.

(2) Unless a petition is filed under this section, a determination under section 3803 of this title that a person is liable under section 3802 of this title shall be final and shall not be subject to judicial review.

(b)(1)(A) Any person who has been determined to be liable under section 3802 of this title pursuant to section 3803 of this title may obtain review of such determination in—

(i) the United States district court for the district in which such person resides or transacts business;

(ii) the United States district court for the district in which the claim or statement upon which the determination of liability is based was made, presented, or submitted; or

(iii) the United States District Court for the District of Columbia.

(B) Such review may be obtained by filing in any such court a written petition that such determination be modified or set aside. Such petition shall be filed—

(i) only after such person has exhausted all administrative remedies under this chapter; and

(ii) within 60 days after the date on which the authority head sends such person a copy of the decision of such authority head under section 3803(i)(2) of this title.

(2) The clerk of the court shall transmit a copy of a petition filed under paragraph (1) of this subsection to the authority and to the Attorney General. Upon receipt of the copy of such petition, the authority shall transmit to the Attorney General the record in the proceeding resulting in the determination of liability under section 3802 of this title. Except as otherwise provided in this section, the district courts of the United States shall have jurisdiction to review the decision, findings, and determinations in issue and to affirm, modify, remand for further consideration, or set aside, in whole or in part, the decision, findings, and determinations of the authority, and to enforce such decision, findings, and determinations to the extent that such decision, findings, and determinations are affirmed or modified.

(c) The decisions, findings, and determinations of the authority with respect to questions of fact shall be final and conclusive, and shall not be set aside unless such decisions, findings, and determinations are found by the court to be unsupported by substantial evidence. In concluding whether the decisions, findings, and determinations of an authority are unsupported by substantial evidence, the court shall review the whole record or those parts of it cited by a party, and due account shall be taken of the rule of prejudicial error.

(d) Any district court reviewing under this section the decision, findings, and determinations of an authority shall not consider any objection that was not raised in the hearing conducted pursuant to section 3803(f) of this title unless a demonstration is made of extraordinary circumstances causing the failure to raise the objection. If any party demonstrates to the satisfaction of the court that additional evidence not presented at such hearing is material and that there were reasonable grounds for the failure to present such evidence at such hearing, the court shall remand the matter to the authority for consideration of such additional evidence.

(e) Upon a final determination by the district court that a person is liable under section 3802 of this title, the court shall enter a final judgment for the appropriate amount in favor of the United States.

§ 3806. Collection of civil penalties and assessments

(a) The Attorney General shall be responsible for judicial enforcement of any civil penalty or assessment imposed pursuant to the provisions of this chapter.

(b) Any penalty or assessment imposed in a determination which has become final pursuant

to this chapter may be recovered in a civil action brought by the Attorney General. In any such action, no matter that was raised or that could have been raised in a hearing conducted under section 3803(f) of this title or pursuant to judicial review under section 3805 of this title may be raised as a defense, and the determination of liability and the determination of amounts of penalties and assessments shall not be subject to review.

(c) The district courts of the United States shall have jurisdiction of any action commenced by the United States under subsection (b) of this section.

(d) Any action under subsection (b) of this section may, without regard to venue requirements, be joined and consolidated with or asserted as a counterclaim, cross-claim, or setoff by the United States in any other civil action which includes as parties the United States and the person against whom such action may be brought.

(e) The United States Court of Federal Claims shall have jurisdiction of any action under subsection (b) of this section to recover any penalty or assessment if the cause of action is asserted by the United States as a counterclaim in a matter pending in such court.

(f) The Attorney General shall have exclusive authority to compromise or settle any penalty or assessment the determination of which is the subject of a pending petition pursuant to section 3805 of this title or a pending action to recover such penalty or assessment pursuant to this section.

(g)(1) Except as provided in paragraph (2) of this subsection, any amount of penalty or assessment collected under this chapter shall be deposited as miscellaneous receipts in the Treasury of the United States.

(2)(A) Any amount of a penalty or assessment imposed by the United States Postal Service under this chapter shall be deposited in the Postal Service Fund established by section 2003 of title 39.

(B) Any amount of a penalty or assessment imposed by the Secretary of Health and Human Services under this chapter with respect to a claim or statement made in connection with old age and survivors benefits under title II of the Social Security Act shall be deposited in the Federal Old-Age and Survivors Insurance Trust Fund.

(C) Any amount of a penalty or assessment imposed by the Secretary of Health and Human Services under this chapter with respect to a claim or statement made in connection with disability benefits under title II of the Social Security Act shall be deposited in the Federal Disability Insurance Trust Fund.

(D) Any amount of a penalty or assessment imposed by the Secretary of Health and Human Services under this chapter with respect to a claim or statement made in connection with benefits under part A of title XVIII of the Social Security Act shall be deposited in the Federal Hospital Insurance Trust Fund.

(E) Any amount of a penalty or assessment imposed by the Secretary of Health and Human Services under this chapter with respect to a claim or statement made in connection with benefits under part B of title XVIII of the Social Security Act shall be deposited in the Federal Supplementary Medical Insurance Trust Fund.

§ 3807. Right to administrative offset

(a) The amount of any penalty or assessment which has become final under section 3803 of this title, or for which a judgment has been entered under section 3805(e) or 3806 of this title, or any amount agreed upon in a settlement or compromise under section 3803(j) or 3806(f) of this title, may be collected by administrative offset under section 3716 of this title, except that an administrative offset may not be made under this subsection against a refund of an overpayment of Federal taxes, then or later owing by the United States to the person liable for such penalty or assessment.

(b) All amounts collected pursuant to this section shall be remitted to the Secretary of the Treasury for deposit in accordance with section 3806(g) of this title.

§ 3808. Limitations

(a) A hearing under section 3803(d)(2) of this title with respect to a claim or statement shall be commenced within 6 years after the date on which such claim or statement is made, presented, or submitted.

(b) A civil action to recover a penalty or assessment under section 3806 of this title shall be commenced within 3 years after the date on which the determination of liability for such penalty or assessment becomes final.

(c) If at any time during the course of proceedings brought pursuant to this chapter the authority head receives or discovers any specific information regarding bribery, gratuities, conflict of interest, or other corruption or similar activity in relation to a false claim or statement, the authority head shall immediately report such information to the Attorney General, and in the case of an authority in which an Office of Inspector General is established by the Inspector General Act of 1978 or by any other Federal law, to the Inspector General of that authority.

§ 3809. Regulations

Within 180 days after the date of enactment of this chapter, each authority head shall promulgate rules and regulations necessary to implement the provisions of this chapter. Such rules and regulations shall—

(1) ensure that investigating officials and reviewing officials are not responsible for conducting the hearing required in section 3803(f) of this title, making the determinations required by subsections (f) and (h) of section 3803 of this title, or making collections under section 3806 of this title; and

(2) require a reviewing official to include in any notice required by section 3803(a)(2) of this title a statement which specifies that the reviewing official has determined that there is a reasonable prospect of collecting, from a person with respect to whom the reviewing official is referring allegations of liability in such notice, the amount for which such person may be liable.

[§ 3810. Repealed. Pub. L. 104–66, title III, § 3001(c)(1), Dec. 21, 1995, 109 Stat. 734]

§ 3811. Effect on other law

(a) This chapter does not diminish the responsibility of any agency to comply with the provisions of chapter 35 of title 44.

(b) This chapter does not supersede the provisions of section 3512 of title 44.

(c) For purposes of this section, the term ‘‘agency’’ has the same meaning as in section 3502(1) of title 44.

§ 3812. Prohibition against delegation

Any function, duty, or responsibility which this chapter specifies be carried out by the Attorney General or an Assistant Attorney General designated by the Attorney General, shall not be delegated to, or carried out by, any other officer or employee of the Department of Justice.

King County Mental Health Plan

Provider Requirements

I. Providers that make or receive $5 million or more in Medicaid payments in a preceding federal fiscal year must establish and adopt written policies about the False Claims Act and other provisions named in section 1902(a)(68) of the Social Security Act for all its employees, contractors, and agents (Attachments B-1 and B-2).

A. Future determinations regarding a provider's responsibility for this requirement will be made by January 1 of each subsequent year based on payments either received or made in the preceding federal fiscal year.

B. If the provider furnishes services at more than a single location or under more than one contract, these provisions apply if the aggregate payments to the provider meet the $5 million threshold. This applies whether the provider uses one or more provider identification or tax identification numbers.

II. The provider must develop and distribute to employees and subcontractors written standards of conduct and policies and procedures that provide:

A. Detailed provisions for detecting and preventing fraud, waste, and abuse that include the following elements:

1. A statement of the provider's commitment to comply with all applicable federal and state standards.

2. Designation of a compliance officer and a compliance committee that is accountable to senior management.

3. Provision of effective ongoing training and education for the compliance officer and staff of the provider.

4. Facilitation of effective communication between the compliance officer and the provider's employees.

5. A process to receive complaints and the adoption of procedures to protect the anonymity of complainants and to protect complainants from retaliation.

6. Enforcement of standards through well-publicized disciplinary guidelines.

7. Provision for internal monitoring and auditing.

8. Provision for prompt response to detected offenses and for development of corrective action initiatives.

9. Reporting of fraud, waste, or abuse information to KCMHP as soon as it is discovered, to include the source of the complaint, the involved employee or subcontractor, the nature of the fraud, waste, or abuse complaint, the approximate dollars involved, and the legal and administrative disposition of the case.

B. Detailed information about the False Claims Act established under sections 3729 through 3722 of title 31 United States Code (U.S.C.) (Attachment B-1).

C. Detailed information about administrative remedies for false claims and statements established under chapter 38 of title 31 U.S.C. (Attachment B-2).

D. State laws pertaining to civil or criminal penalties for false claims and statements (Attachment B-4).

E. Whistleblower protections under such laws with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (Attachment B-4).

III. The provider must include in any employee handbook for the provider, a specific discussion of the laws described above, the rights of employees to be protected as whistleblowers, and the provider's policies and procedures for detecting and preventing fraud, waste, and abuse. The provider need not create an employee handbook if none already exists.

King County Mental Health Plan

Employee Education about False Claims Recovery

What is the federal law?

Section 6033 of the Federal Deficit Reduction Act of 2005, effective January 1, 2007, requires any "entity" receiving or making annual Medicaid payments of $5 million or more to establish and adopt written policies about the False Claims Act and other provisions named in section 1902(a)(68) of the Social Security Act for all its employees, contractors, and agents.

What is an entity?

An entity includes any of the following, whether for-profit or not-for-profit, that receives or makes $5 million or more in Medicaid payments under a State Plan for Medical Assistance:

- Governmental agency;
- Organization;
- Unit;
- Corporation;
- Partnership; and
- Other business arrangement (including any Medicaid managed care organizations, state mental health facilities, and school districts providing school-based health services).

A provider of Medicaid healthcare items and services will be considered an entity if the provider made or received $5 million or more in Medicaid payments during the preceding federal fiscal year (e.g., the federal fiscal year 2009 begins October 1, 2008 and ends September 30, 2009). Covered entities will be determined yearly.

What does the federal law require entities to do?

An entity must establish written polices for all employees (including management) and any contractors or agents of the entity, that include detailed information about the False Claims Act and other provisions named in section 1902(a)(68). These policies must include detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse.

The entity must also include in any employee handbook:

- A specific discussion of the laws described in the written policies;
- The rights of employees to be protected as whistleblowers; and
- A specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

There is no requirement that an entity create an employee handbook if none already exists.

Do I or my employer have to comply with the new federal regulation?

Yes, if you or your employer make or receive $5 million or more**:**

- In payments through a single location or contractual arrangement, or
- In aggregate payments through more than one location or under more than one contractual or other payment arrangement. This applies if you submit claims for payments using one or more provider identification or tax identification numbers,

- You are required, as a condition of receiving or making such payments, to comply with section 1902(a)(68) of the Social Security Act, effective January 1, 2007.

No, if you or your employer make or receive less than $5 million in payments.

What is the penalty for knowingly making a false or fraudulent Medicaid claim?

Any person who submits a claim for Medicaid reimbursement that he or she knows (or should know) is false is liable for a civil penalty of not less than $5,000 and not more than $10,000, plus three times the amount of damages. Examples of false or fraudulent Medicaid claims include:

- Billing for services not provided or for more services than were provided
- Submitting a false record
- Filing a false cost report to avoid making a refund for an overpayment

I'm afraid I'll lose my job or be demoted if I report fraud by my employer. Does the law protect me from any reprisals for filing a report?

Yes. Employees have the right to be protected as whistleblowers.

Where can I find more detailed information on fraud, waste, and abuse and whistleblower protections?

Citation	Federal, State, and County Rules and Regulations
31 United States Code (USC) 3729-3733	Federal False Claims Act: http://uscode.house.gov/pdf/2005/2005usc31.pdf
31 USC Chapter 38	Federal administrative remedies for false claims and statements: http://uscode.house.gov/pdf/2005/2005usc31.pdf
42 USC 1320a-7b	Federal definition of fraud, waste, and abuse: http://uscode.house.gov/pdf/2006/2006usc42pt1.pdf (see page 1827)
Revised Code of Washington (RCW) 74.09.230	State penalties for false statements, fraud: http://apps.leg.wa.gov/RCW/default.aspx?cite=74.09.230
Chapter 388-502A Washington Administrative Code (WAC)	State provider audits and appeals: http://apps.leg.wa.gov/WAC/default.aspx?cite=388-502A
RCW 43.70.075	State whistleblower protection: http://apps.leg.wa.gov/RCW/default.aspx?cite=43.70.075
RCW 49.60.210	State unfair practice to retaliate against whistleblower: http://apps.leg.wa.gov/RCW/default.aspx?cite=49.60.210
King County Code Title 3, §3.42	King County Code, Whistleblower Protections for county employees: http://www.kingcounty.gov/council/legislation/kc_code.aspx King County Office of Citizen Complaints – Ombudsman (for county employees): http://your.kingcounty.gov/ombudsman/PDFs/whistleblowerp.pdf

Action	See Section III.11.0.
Adjustment	A process whereby changes to provider payments are made as a result of policy and procedure.
Adult	A person 18 years of age or older but less than 60 years of age who is receiving services under any program other than a children's program. Note: A person 18 through 20 years of age may be authorized to either a child benefit or an adult benefit.
Adult Crisis Services	Specialized adult crisis services for adults 18 or older who are not enrolled in KCMHP outpatient or residential services. The service provides next day appointments and follow-up care, both in and out of facility, until the crisis has stabilized.
Adult Family Home	A regular family abode in which a person or persons provide room and board, personal care, and/or special care to more than one but not more than six adults who are not related by blood or marriage to the person(s) providing the services.
Advance Directive	A written instruction, such as a living will or durable power of attorney for health care, relating to the provision of health care (including mental health care) when the individual is incapacitated.
Agency	For purposes of the KCMHP, this refers to licensed community mental health centers credentialed to provide mental health services to Prepaid Health Plan clients and families; also called a provider.
Allied System Provider	An agency or person representing an allied system that provides direct services to clients and their families.
Allied System	An organization in close relationship to the mental health system responsible for the provision of services (that are not classified as mental health services) to clients and families.
Appeal	A term that applies to only Medicaid clients and is a request for a review of any Action.
Authorization	The activity by KCMHP in which a level of care or a specific service is determined to be medically necessary.

Boundary Spanner

A member of a forensic treatment team (e.g. IDDT, FACT, FISH, etc.) who has knowledge and expertise working in and navigating the criminal justice system and the human services/ treatment system, can assist participants in navigating system components, has expertise in and knowledge of other relevant systems (e.g. housing), works closely with courts and jails in King County to coordinate referrals, and serves as the entry point of contact to the designated program.

Breach

As it relates to HIPAA Privacy & Security, breach means the unauthorized acquisition, access, use, or disclosure of protected health information which compromises the security or privacy of such information, except where an unauthorized person to whom such information is disclosed would not reasonably have been able to retain such information.

Exceptions: The term 'breach' does not include:

a) Any unintentional acquisition, access, or use of protected health information by an employee or individual acting under the authority of a covered entity or business associate if (a) such acquisition, access, or use was made in good faith and within the course and scope of the employment or other professional relationship of such employee or individual, respectively, with the covered entity or business associate; and (b) such information is not further acquired, accessed, used, or disclosed by any person;

b) Any inadvertent disclosure from an individual who is otherwise authorized to access protected health information at a facility operated by a covered entity or business associate to another similarly situated individual at same facility; or

c) Any such information received as a result of such disclosure is not further acquired, accessed, used, or disclosed without authorization by any person (45 Code of Federal Regulations Part 164.402 Definitions).

Care Coordination

A process-oriented activity to facilitate ongoing communication and collaboration to address the multiple needs of an individual to achieve optimal health and wellness outcomes. Care coordination includes facilitating communication between the family, natural supports, community resources, and involved providers and agencies, organizing, facilitating and participating in team meetings, and providing for continuity of care by creating linkages to and managing transitions between levels of care.

Care Plan	See Individual Service Plan
Case Management	Coordination and provision of treatment that ensure access to needed services and continuity of care through the development of individual service plans. This is one of the core services of the KCMHP.
Case Mix	The distribution of populations (persons receiving outpatient services) across the case-rate authorizations.
Case Rate	A payment level approved for each person authorized for an outpatient or residential benefit payable to a provider. Rates are based on a medical necessity assessment that determines a service intensity level. Rates are further adjusted based on age group (child or adult) and for cultural and language differentials.
Catastrophic and Permanent	A catastrophic and permanent change refers to an unanticipated, substantial and irreversible medical or psychiatric change in the way a client meets authorization criteria, compelling the request for a new benefit for an already authorized client.
Child/Adolescent	A person who is less than 21 years of age and is receiving services under any children's program. Note: A person 18 through 20 years of age may be authorized to either a child or an adult benefit.
Child and Family Team	A group chosen by the child, youth, and/or family who will support them to meet their needs across life domains. The team is comprised of members who continue to support the family when professionals are no longer involved.
Children's Crisis Outreach Response System (CCORS)	Crisis services, stabilization, and referral for children, youth, and families in crisis in King County.
Children's Long-Term Inpatient Program (CLIP)	The state-appointed authority for policy and clinical decision-making regarding admission to and discharge from state-funded beds in the children's long-term inpatient programs (Child Study and Treatment Center, Pearl Street Center, McGraw Center, and Tamarack Center).
Children's Global Assessment Scale (CGAS)	A level of functioning assessment scale for children 6 through 20 years of age, published in the Diagnostic and Statistical Manual for Psychiatric Disorders (DSM). The CGAS is one of the indicators used to establish medical necessity for outpatient services.

Chronically Homeless	A person who has either been continually homeless for a year or has had at least four episodes of homelessness in the past three years
Children's Program	A mental health program that can serve people up to 21 years of age.
Client	A person who has been determined to meet both financial eligibility and medical necessity criteria, and has therefore been authorized for any KCMHP-funded services.
Client Lookup System (CLS)	The MHCADSD IS application that allows authorized users to access information on individuals to determine if they are receiving services from KCMHP providers.
Client Services	A KCMHP staff member who accepts calls and correspondence from clients, potential clients, and family members; answers questions regarding benefits, eligibility, access to care; and receives and attempts to resolve complaints and grievances.
Clinical Review	Review of services provided to a client in order to evaluate the quality of care and the impact on the outcome of treatment and/or to verify medical necessity.
Community-Based	Service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible and that safely promote client and family integration into home and community life.
Complaint	Any client expression of dissatisfaction that is resolved to the client's satisfaction through simple, first level dialog.
Community Mental Health Agency (CMHA)	A licensed mental health center.
Confidentiality	The ethical principle bound by statute that a mental health professional may not reveal any information disclosed in the course of mental health treatment, including the fact of providing treatment.
Continued Stay Criteria	The minimum criteria to receive an additional authorization for a specific level of care.
Co-Occurring Disorder (COD) Integrated Treatment Services	Intensive service program for adults with co-occurring mental and substance use disorders who also have high utilization of the King County Department of Adult and Juvenile Detention adult detention facilities.

Coordinated Services and Supports	Services and supports planned in a coordinated manner between provider agencies, clients and families, and community organizations. Service plans are complimentary between agencies.
Corrective Action Plan	A written plan specifying provider requirements to correct identified deficiencies, the plan may include a timeline for such action and consequences of lack of action.
Crisis Evaluation	Single face-to-face contact that involves clinical formulation of need for short-term services to address a specific crisis.
Crisis Service	A response to urgent and emergent mental health needs of persons in the community. The goal of this service is to stabilize the individual and family in the least restrictive setting appropriate to their needs, considering strengths, resources, and choice. Interventions shall be age and developmentally appropriate and shall contribute to and support the individual's innate resiliency and recovery.
Crisis Stabilization Placement	Short-term intervention to help children, youth, and families not otherwise enrolled in KCMHP, through a crisis. These beds are available for children requiring immediate out-of-home placements who lack family or natural resources to safely rely upon. See Hospital Diversion Beds-children.
Cultural Assessment	A holistic evaluation of the person that encompasses the cultural, sociological, economic, political, and religious contexts that may influence his/her perceptions and decisions. This evaluation is performed by a specialist as defined by Chapter 388-865 Washington Administrative Code (WAC) and results in ongoing appropriate and relevant service planning.
Cultural Competence	Per Chapter 388-865 WAC, a set of congruent behaviors, attitudes, and policies that come together in a system or agency and enable that system or agency to work effectively in cross-cultural situations. A culturally competent system of care acknowledges and incorporates at all levels the importance of language and culture, assessment of cross-cultural relations, knowledge and acceptance of dynamics of cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs.

Cultural Differential	An adjustment in the case rate for each outpatient benefit to support services to clients who are ethnic minorities, sexual minorities, deaf or hard of hearing or non-facility-based medically compromised homebound individuals. The cultural differential payment rate is based on being a member of any one or more of these groups; the payment is not additive if the client belongs to more than one group.
Culture	An integrated pattern of human behavior, which includes and is not limited to: thought, communication, languages, beliefs, values, practices, customs, courtesies, rituals, manners of interacting, roles, relationships, and the expected behaviors of a racial, ethnic, religious, social, or political group; the ability to transmit the above to succeeding generations; and dynamic in nature.
Deaf	A hearing impairment of such severity that the individual must depend primarily upon visual communication such as writing, lip reading, manual communication, and gestures. In general, an individual with a loss exceeding 80 decibels in the conversational range is considered to be deaf.
Designated Mental Health Professional (DMHP)	The only person legally authorized in Washington to file an official Involuntary Treatment Order for persons 13 or older. In King County, DMHP are staff of Crisis and Commitment Services.
Diagnostic Classification: 0-3R (DC:0-3R)	Diagnostic classifications of mental health and developmental disorders of infancy and early childhood from Zero to Three, Revised Edition published by Zero to Three Press, Washington, D.C., 2005. These codes identify specific diagnoses for children less than six years of age and may be used to establish medical necessity for outpatient benefits.
Disagreement with Treatment Plan	Occurs when a client indicates disagreement with specific treatment recommendations after all options for resolving the disagreement have been exhausted.
Early Periodic Screening, Diagnosis and Treatment (EPSDT)	The federally mandated program for Medicaid children under age 21 which directs that all children at or below the poverty level be screened for health problems (including mental health) and provided with appropriate services to treat any identified medical issues.

Emergent Care	Emergent care are those services that, if not provided, would likely result in the need for crisis intervention or hospitalization due to imminent concerns about potential danger to self, others, or grave disability. Emergency crisis services must be initiated within two hours of the initial request from any source. Examples include phone crisis services, CCS services, CCORS services, hospital diversion beds, and crisis stabilization services.
Enrollee	A Medicaid recipient.
Ethnic minority	For the purpose of qualifying for the cultural differential case rate, ethnic minority means a person who self identifies as any of the following: African American/Other Black; Asian American/Pacific Islander; Native American; Hispanic; or Other/Mixed Race.
Evaluation and Treatment (E&T) Facility	Any facility certified by the State Department of Social and Health Services to provide short-term, involuntary inpatient mental health treatment.
Extraordinary Treatment Plan (ETP)	A plan for services when a client has treatment needs that exceed the most service-intensive benefit within the KCMHP outpatient or residential levels of care.
Facilitator	A person who maintains the principles of the wraparound process for an ongoing team. The facilitator coordinates the wraparound process and is responsible for guiding, motivating, or undertaking the various activities.
Fair Hearing	A grievance hearing before the Washington State Office of Administrative Hearings.
Family	A group of individuals who support the client emotionally, physically, and/or financially. A family is defined by its members and each family defines itself. A family can include individuals of various ages who are biologically related, related by marriage, or not related at all.
Family-Centered	The family voice is heard and integrated throughout policy, program development, and service delivery. Services have moved from family-as-client to family-as-partner. Services are "done with" the family, rather than "done to" the family.
Family-Centered Practices	The needs and goals of the family are a priority of determining how and when services are rendered. Goals and desired outcomes are mutually defined, as are the resources needed to achieve them. Care planning utilizes existing and potential natural supports.

Family Friendly	Actions and environments that promote and welcome family members to actively participate in their care.
Family Integrated Transitions Program (FIT)	There are two programs: one funded through the State Juvenile Rehabilitation Administration (JRA) is for youth transitioning from incarceration at a JRA facility to the community; the other is funded through Superior Court for youth transitioning from the local detention facility to the community.
Family Partnership	Contributing to a joint venture with the child and family-usually sharing its risks and benefits. Requires joint decision making power and the shared distribution of benefits or losses.
Financial Exploitation	The illegal or improper use of the property, income, resources, or trust funds of a vulnerable adult by any person for any person's profit or advantage (per Revised Code of Washington [RCW] 74.34.020).
Flag	An indicator that identifies client-centered circumstances or situations that have implications for utilization management or financial management. Flags could: (1) include indicators that trigger the payment of the cultural differential case rate; (2) identify individuals who are high users of inpatient or crisis services; or (3) identify individuals who have an unusual service pattern.
Forensic Assertive Community Treatment (FACT)	A recovery-oriented and self-contained mental health service delivery program for the criminal justice-involved population that uses a trans-disciplinary team treatment approach designed to provide comprehensive, community-based psychiatric treatment, rehabilitation, and support to persons with serious and persistent mental illness. FACT Core Elements are: 1. Participants have criminal justice histories; 2. Participants are referred/identified by criminal justice agencies; 3. Goal of preventing participants from being arrested and incarcerated; and 4. Availability of 24 hours-a-day, seven days-a-week, supervised supportive housing component for high-risk participants, including those with COD.

Forensic Integrated Reentry Support and Treatment (FIRST), formerly MIO-CTP	A program to plan and provide coordinated pre-release discharge planning and post-release case management services to individuals with a mental illness being released from Department of Corrections custody. Services shall include intensive outreach and engagement, community treatment, and residential supports.
Frequent Use	A criterion for a non-Medicaid benefit, meaning at least two uses of any single resource or two uses of any combination of resources within the year previous to the referral date.
Geriatric Regional Assessment Team (GRAT)	Stabilization services for older adults who reside in King County but are not enrolled in the KCMHP and who are experiencing multiple physical, mental, and social problems.
Global Assessment of Functioning (GAF) Scale	A level of functioning assessment scale for adults 18 years of age or older, published in the current Diagnostic and Statistical Manual for Psychiatric Disorders (DSM). The GAF is one of the indicators used to establish medical necessity for outpatient services.
Grievance	An expression of dissatisfaction about RSN related services other than an Action that is not resolved to the client's satisfaction through simple, first level dialog.
Guidelines	Accepted good practice which is recommended for use, not required.
Hard of Hearing	A hearing impairment resulting in a functional loss, but not to the extent the individual must depend primarily upon visual or tactile communication. The hearing loss should be a significant factor in the symptoms of the mental illness (e.g., increasing anxiety, suspiciousness, or isolation), in the person's level of functioning, or in the provision of treatment.
High Utilization	Three or more psychiatric hospitalizations in the previous 12 months.
Homeless	Persons who lack a fixed, regular, and adequate night-time residence. For additional information, refer to the Data Dictionary in Section XII: Information Management, Attachment B, Residential Arrangement Code 82.
Homeless Outreach, Stabilization and Transition (HOST) Project	A project that provides outreach and engagement, intensive stabilization, transition to ongoing services, and reengagement into services for persons who are mentally ill and homeless.

Hospital Diversion Beds – Adult	Beds available to all adults who are King County residents who can be appropriately diverted from an inpatient psychiatric hospital admission if given this service.
Hospital Diversion Beds – Children/Youth	Beds available to children/youth who are authorized for outpatient level of care and who can be appropriately diverted from an inpatient psychiatric hospital admission if given this service.
Institution for Mental Diseases (IMD)	As defined in the Code of Federal Regulations, "Institution for mental diseases means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for the mentally retarded is not an institution for mental diseases." Medicaid funding cannot be used for persons in IMDs who are age 22 through age 64, and the state determines if a facility is an IMD.
Individual Service Plan (ISP)	An action plan mutually developed by the provider with the client and others providing supports to the client that describes the services and supports (Per WAC 388-865-0425) with client goals and steps to achieve recovery.
Initial Crisis Outreach	A crisis service provided by the DMHP's 7 days a week, 24-hours-a day. These are one-time-only contacts, provided face-to-face in community-based settings for persons in crisis for whom a mental disorder cannot be ruled out.
Inpatient	A person receiving publicly funded psychiatric services in an inpatient facility, including evaluation and treatment facilities.
Inpatient Diversion Beds (see Hospital Diversion Beds – Adult)	A short-stay crisis bed in a residential facility that provides 24-hour staff supervision. The goal is to avert immediate voluntary or involuntary hospitalization for those persons who need very short-term supervision during times of emotional crisis in order to ensure their safety or the safety of others.
Intake	That part of the assessment process during which initial information on the client is collected.

Integrated Dual Disorder Treatment (IDDT)	An evidence-based practice recognized by the United States Department of Health and Human Services Substance Abuse and Mental Health Services Administration to be effective in the recovery process for consumers with COD. In IDDT, the same clinicians or team of clinicians work in one setting and provide mental health and substance abuse interventions in fully coordinated service delivery. Critical elements of IDDT include assertive outreach, motivational interventions, and a comprehensive, staged, client-centered approach to recovery.
Involuntary Treatment/Commitment	Evaluation and action ordered by a DMHP and/or a Superior Court Judge for persons with a mental disorder who have demonstrated behavior that is dangerous to self or others; or have substantially harmed someone else's property; or are so gravely disabled that they are unable to provide for basic needs and are not receiving essential care for health and safety.
ITA Detained Person	Any person seen face-to-face under the provision of the Involuntary Treatment Act, Chapters 71.05 or 71.34 RCW, and subsequently detained for inpatient psychiatric treatment.
King County Care Partners	A program that offers case management services for a six-month interval for persons who are high utilizers of medical services and receive Medicaid through the adult, blind, or disabled programs. The lead agency for this program is the City of Seattle Aging and Disability Services.
KCMHP Client	A person receiving services under the King County Mental Health Plan.
King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD)	A division of the King County Department of Community and Human Services that is responsible for policy development and planning for the publicly funded mental health system in King County. MHCADSD oversees both the Regional Support Network and the Prepaid Health Plan. MHCADSD is also responsible for Chemical Dependency services in King County.
Levels of Care	The organization of KCMHP services into groups that reflect differences in the intensity of client need and the best way to deliver services that respond to that need. There are four levels of care: crisis services, outpatient services, residential services, and inpatient services.

Long-Term Rehabilitation (LTR)	A 24-hour supervised residential treatment program for adults who: 1) require 24-hour supervision; 2) do not require extensive medical care; 3) have a severe functional or behavioral impairment as a result of a psychiatric disorder; and/or 4) do not follow or do not have effective medications.
Managed Care	An integrated system managing access and intensity and duration of care through defined standards, expected outcomes, quality indicators, and planned expenditures.
Medicaid Abuse	Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. Abuse also includes beneficiary practices that result in unnecessary cost to the KCMHP. Medicaid Managed Care Abuse means practices in a capitated Managed Care Option (MCO), Primary Care Case Management (PCCM) program, or other managed care setting, that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or contractual obligations for health care. The abuse can be committed by an MCO, contractor, subcontractor, provider, state employee, Medicaid beneficiary, or Medicaid managed care enrollee, among others. It also includes beneficiary practices in a capitated MCO, PCCM program, or other managed care setting that result in unnecessary cost to the Medicaid program, or MCO, contractor, subcontractor, or provider. A provider can be defined as any individual or entity that receives Medicaid funds in exchange for providing a service (MCO, contractor, or subcontractor). It should be noted that Medicaid funds paid to an MCO, then passing to subcontractors, are still Medicaid funds from a fraud and abuse perspective.
Medicaid Eligibility Lookup System (MELS)	Application that allows authorized users to obtain Medicaid eligibility information on a specific client.

Medicaid Fraud	Medicaid Managed Care Fraud means any type of intentional deception or misrepresentation made by an entity or person in a capitated MCO or PCCM program, or other managed care setting, with the knowledge that the deception could result in some unauthorized benefit to the entity, to the person himself/ herself, or to some other person. A provider can be defined as any individual or entity receiving Medicaid funds in exchange for providing a service (MCO, contractor, or subcontractor).
Medicaid Recipient	An individual who is currently enrolled in the Medicaid program.
Medically Necessary/Medical Necessity	A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions in the recipient that endanger life, cause suffering or pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all (WAC 388-865-0150).
Mental Health Care Provider (MHCP)	The professional with primary responsibility for implementing an individual service plan for outpatient mental health rehabilitation services and/or community psychiatric inpatient care to be provided to the service recipient (Chapter 388-865 WAC). The MHCP is the assigned provider staff person who may be called a care coordinator, case manager, therapist, or other title. Minimum qualifications are B.A. level in a related field or A.A. level with two years experience in the mental health or related fields.
Mental Health, Chemical Abuse and Dependency Services Division Information System (MHCADSD IS)	Contains client, staff, and service information submitted by MHP providers, State CMHIS, HHIS, High Utilization Reports, Medicaid data, Crisis and Commitment Services database, Extended Client Lookup System (ECLS).
Mental Health Court	A specialized court for misdemeanor defendants with mental illness. Defendants work with a team of specialists, including a judge, prosecutor, defender, court monitor, treatment provider and probation officer, to receive court-ordered treatment as a diversion from prosecution or as a sentencing alternative.

Mental Health Information System (MHIS)	The total electronic information system and network used by the state, KCMHP, and contracted providers to collect, store, and disseminate information concerning client participation in mental health services. Includes the State Client Information System, the State CMLS, the MHCADSD IS, and the information systems of KCMHP providers.
Moral Reconation Therapy (MRT)	A systematic treatment strategy that seeks to decrease recidivism among adult criminal offenders by increasing moral reasoning. This cognitive-behavioral approach combines elements from a variety of psychological traditions to progressively address ego, social, moral, and positive behavioral growth. MRT takes the form of group and individual counseling using structured group exercises and prescribed homework assignments.
Multi-System Involved	Any person who is receiving services from or is formally involved with more than one service system. Typically individuals would be involved with the mental health system and at least one other system like the criminal justice system and/or the child welfare system.
Multisystemic Therapy (MST)	Multisystemic therapy (MST) is an empirically proven program that provides intensive family-based treatment addressing the known determinants of serious antisocial behavior in adolescents and their families. Only staff designated by the King County Superior Court Project Manager may make referrals to the MST Program.
Natural Supports	Any person or organization contributing to positive outcomes that is not a formal treatment or intervention service or any supports provided by individuals or organizations in the family's own community, kinship, social, or spiritual networks.
Non-Facility-Based Medically Compromised Homebound Client	A client who has a chronic medical, physical, or psychiatric condition that causes significant disability such that the individual is 1) unable to leave home, or 2) if leaving home is possible, this occurs infrequently, is usually for the purpose of receiving medical care and requires considerable effort, supervision, or assistance. Because of this difficulty or inability to leave home, the medically compromised homebound individual is unable to utilize services if provided only in a clinic. The client does not reside in a residential facility or nursing home type environment. This disability designation, when verified by residential arrangement data in the MHCADSD IS, triggers the cultural differential case rates add-on.

Non-Medicaid	Persons who do not hold a valid card showing they meet Medicaid eligibility requirements. Mental health services will be available to non-Medicaid persons as resources permit.
Notice of Action	A written statement sent to a Medicaid clients and his/her requesting provider when 1) covered mental health services have been requested on the client's behalf and the request has been denied by the KCMHP; 2) services previously authorized by the KCMHP have been suspended, reduced or terminated; or 3) a provider is denied payment for services already given the client. The Notice includes the KCMHP decision, the rationale for the decision, and instruction on how the client may appeal the decision and the help available to the client in doing so.
Notice of Determination	A written statement sent to a Medicaid or non-Medicaid client and his/her requesting provider when outpatient or residential mental health services have been authorized by the KCMHP for the client. Additionally, Notices of Determination are sent to non-Medicaid clients in all the instances in which a Medicaid client would get a Notice of Action. The content of the Notices of Determination mirrors the content of the Notices of Action except for those instances where non-Medicaid clients have different rights.
Older Adult	A person 60 years of age or older who is receiving services from the KCMHP.
Older Adult Crisis Services	See Geriatric Regional Assessment Team.
Ombuds Service	An advocacy service for clients and family members primarily staffed by current or former clients or family members who provide assistance with questions, complaints, and/or grievances with publicly funded mental health services. Development of the service is based upon Washington Administrative Code (WAC) requirements.
Outcome Measure(s)	Specific information that demonstrates what happens to individuals as a result of the mental health care they receive. Individual outcomes for mental health care under the KCMHP are specifically defined for each client depending on age and the level of care he/she will receive.
Outreach	Mental health services provided to KCMHP clients in their places of residence or in non-traditional settings. There are two basic approaches to outreach – mobile (going to them) and drop-in centers (shelters, clubhouses, kitchens, clothing banks, etc.).

Parent-Infant Relationship Global Assessment Scale (PIR-GAS)	An assessment scale for children under the age of six. The PIR-GAS is one of the indicators used to establish medical necessity for outpatient services.
Peer Bridger	A peer bridger is a state Certified Peer Support specialist who works with an inpatient treatment team on behalf of a hospitalized individual to facilitate successful transition to community based services and supports.
Penetration Rate	The percentage of Medicaid individuals using publicly funded mental health services out of the total population of Medicaid eligible individuals.
Performance Indicator(s)	System-level information about access, services provided, clinical characteristics, clinical outcomes, and finances.
Pre-Admission Screening and Annual Residential Review (PASARR)	For individuals who are found to need mental health services in King County as a result of receiving an evaluation either before or after placement in a nursing facility. Upon receipt of this review form, KCMHP will assign the case to an appropriate provider for provision of services and request a face-to-face assessment within 30 days.
Prepaid Inpatient Health Plan (PIHP)	An entity, under contract with the state and funded by prepaid capitation payments, that provides, arranges for, or otherwise has responsibility for the provision of any inpatient or institutional services for its enrollees and does not have a comprehensive (i.e. primary health care) contract.
Prevalent Languages	The DSHS prevalent languages are: Cambodian, Chinese, English, Korean, Laotian, Russian, Somali, Spanish, and Vietnamese.
Prevocational Services	Services based on individual need that prepare a person to seek work. Such services principally include improving skills in resume preparation, application writing, interviewing, and specific work-site-related behaviors such as punctuality, employer-employee relations, and hygiene.
Primary Care Provider (PCP), Primary Care Provider Mental Health (PCPMH)	See Mental Health Care Provider.
Program for All-Inclusive Care of the Elderly (PACE)	A Medicare/Medicaid program for older adults offered through Providence Elder Care. This program allows frail elderly people who would qualify medically for a nursing home placement to live in their communities. A person enrolled in this program is not eligible for concurrent outpatient benefits.

Program for Assertive Community Treatment (PACT)	An evidence-based service delivery model for providing comprehensive community-based treatment to persons with the most serious and persistent mental illnesses that have not benefited from traditional outpatient programs. Key component elements include: team approach, small caseload, individualized treatment, fixed point of responsibility, in-vivo assistance, time-unlimited services, and 24/7 crisis response.
Provider	A term that indicates a contracted agency that provides mental health services within the KCMHP. May also refer to a facility or an individual.
ProviderOne	ProviderOne is the Department of Social and Health Services (DSHS) primary provider payment processing system. Payments previously processed in the Medicaid Management Information System (MMIS) and the Social Services Payment System (SSPS), as well as many manual payments, are consolidated in the ProviderOne system.
Provider Profile	A compilation of information about a contracted provider of KCMHP outpatient services. The profile includes populations served, clinical practice information, and clinical outcomes.
Psychotherapy	The client-centered treatment of emotional, behavioral, personality and psychiatric disorders based primarily upon verbal or non-verbal communication with the client in contrast to treatments utilizing chemical or physical measures.
Quality Assurance (QA)	A focus on compliance to minimum standards (e.g., rules, regulations, contract terms) as well as reasonably expected levels of performance, quality, and practice.
Quality Improvement	A focus on activities to improve performance above minimum standards, reasonably expected levels of performance, quality, and practice.
Quality Management	A system and/or process whereby quality assurance and quality improvement activities are incorporated and infused into all aspects of an organization’s or system’s operations.
Quality Review Team (QRT)	An independent team per Chapter 388-865 WAC that works closely with clients and families to review provider, RSN, and KCMHP performance.
Recovery	Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Regional Support Network (RSN)	An entity created by legislation that is responsible for the establishment and coordination of a plan for mental health services (residential and community support) for clients/consumers on a regional level (county authority) through joint operating agreements with the State. The KCMHP is managed by the RSN.
RSN Demographic Search	Archival database available on the state DSHS computer system that allows authorized users to access information on a mental health client to determine his or her enrollment status in any county in the State of Washington.
Resiliency	The personal and community qualities that enable individuals to rebound from adversity, trauma, tragedy, threats, or other stresses and to live productive lives. (RCW 71.24.025)
Routine Care	Services intended to stabilize, sustain, and facilitate consumer recovery within his or her living situation. These services do not meet the definition of urgent or emergent care.
Routine Services	See Routine Care.
Screening	The process by which a provider evaluates persons who present for service and determines the appropriate referral.
Service Populations	See above for individual definitions of Child, Adult, and Older Adult.
Seriously Emotionally Disturbed (SED)	An infant or child who has been determined to be experiencing a mental disorder as defined in Chapter 71.34 RCW, including those mental disorders that result in a behavioral or conduct disorder, that is clearly interfering with the child's functioning in family or school or with peers, and who meets at least one of the following criteria: a) Has undergone inpatient treatment or placement outside of the home related to a mental disorder within the last two years; b) Has undergone involuntary treatment under Chapter 71.34 RCW within the last two years; c) Is currently served by at least one of the following child serving systems: juvenile justice, child-protection/welfare, special education, or developmental disabilities; d) Is at risk of escalating maladjustment due to: i. Chronic family dysfunction involving a mentally ill or inadequate caretaker;

(Continued: SED)	ii. Changes in custodial adult; iii. Going to, residing in, or returning from any placement outside of the home, for example, psychiatric hospital, short-term inpatient or residential treatment, group or foster home, or a correctional facility.
Sexual Minority	A person who self-identifies as: a) lesbian; or b) gay male; or c) bi-sexual; or d) transgender; or e) questioning her/his sexual orientation and/or gender identity.
Standard Supportive Housing (SSH)	Standard Supportive Housing (SSH) services are for clients who may require regular staff contact and the availability of staff 24 hours-a-day, seven days-a-week, but who do not need the physical safety and structure of a residential facility. Clients may be housed in cluster or independent settings.
Stars	Intensive service program for persons with developmental disabilities and substance use disorders.
Supervised Living (SL)	Any residential service program including but not necessarily limited to an Adult Family Home or Congregate Care Facility (see separate definitions) in which staff provide 24-hour on-site supervision. Additional treatment services may be provided in this setting as part of the outpatient authorized benefit.
Supported Employment (SE)	An evidence-based practice that assists persons diagnosed with serious and persistent mental illness obtain and maintain community-integrated employment that pays at least minimum wage. The practice focuses on defining a participant's circumstances, capabilities, and level of motivation, then adds the supports to assist the participant in finding and retaining an appropriate job.
System of Care	A comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and their families.

System Collaboration	The organization and coordination of resources available through federal, state, and local human service systems responsible for serving individuals and their families. Strategic planning, consolidation of funding streams, and policy formation are examples of tools that promote system collaboration and integration.
Termination Criteria	The criteria necessary for termination of an authorization for a specific level of care.
Tier Benefit	See Case Rate.
Trauma-Informed Care (TIC)	Trauma-Informed Care is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.
TTY or TDD	Teletypewriter or Telecommunications Device for the Deaf. Both acronyms refer to a device that allows deaf individuals to make a telephone call directly, without the use of another person to interpret.
Urgent Care	Urgent care services are those services that, if not provided, would result in decomposition to the point that emergency care is necessary. Urgent crisis services must be initiated within 24 hours of the initial request from any source. Examples include CCS services, CCORS services, hospital diversion beds, and crisis stabilization services.
Utilization Review (UR)	The process of evaluating the use of services, procedures, and facilities by comparison with pre-established criteria.
Vocational Services	Services based on individual needs which support a person to gain and retain employment. Such services principally include vocational assessment, job development, job placement, and job coaching. Vocational services may also include medical diagnostics, training, transportation, and provision of tools, equipment and uniforms or work clothes.
Wait List	Any amount of time a non-Medicaid client is expected to wait for services beyond the established access standards.
Waiver	The document by which DSHS requests sections of the Social Security Act be waived in order to operate a capitated managed care system to provide services to enrolled recipients.

Waste	Means the expenditure or allocation of resources or provision of services significantly in excess of need. Waste need not involve an element of private use nor of personal gain, but invariably signifies poor management resulting in the misuse of resources.
Wellness Recovery Action Plan (WRAP)	A self-management and structured recovery system designed to decrease and prevent intrusive or troubling feelings and behaviors, increase personal empowerment, improve quality of life, and assist persons in achieving their own life goals.
Wraparound	A model of needs-driven and strengths-based planning through a facilitated team process. The client and family are supported by a team of people that includes natural/community supports and professionals, eventually evolving to a team of community supports.
Wraparound Collaboration	A process in which team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single wraparound care plan.
Youth	A person who is between the ages of 13 and 20 years of age receiving services under any children's program.