

Pathways to Well-Being Including Katie A. Subclass

The Katie A. v. Bonta lawsuit settlement that established the Katie A. Subclass, and the subsequent Pathways to Well-Being expansion have identified children and youth under the age of 21 who are eligible through the EPSDT benefit for Specialty Mental Health Services (SMHS) and meet medical necessity for three specific, intensive services: Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC). Individualized determinations of need for ICC, IHBS, and TFC must be made using medical necessity criteria. Eligibility for the services is determined through a formal process – consult with your supervisor about these steps. These services are appropriate for clients with more intensive needs or who are in or at risk of placement in residential or hospital settings, but who could be effectively served in the home and community. These services must be provided in a manner consistent with the Department of Health Care Services (DHCS) and California Department of Social Services (CDSS) Core Practice Model (CPM) values and principles, and are provided in conjunction with a Child and Family Team (CFT) which guides the delivery of integrated and coordinated services. Following is a link to the Core Practice Model Guide:

<http://www.childsworld.ca.gov/res/pdf/CorePracticeModelGuide.pdf>

See Process Manual for Katie A. Subclass and Pathways to Well-Being criteria.

Who Can Use These Codes?

	Physician	PA	NP	RN	RN with MH/MA	LVN or Psych Tech	L/R/W Psych	L/R/W LCSW/ASW, MFT/MFTI, LPCC/LPCCI	Trainee - post BA/BS and pre MA/MS/PhD	MHRS	Other, Unlicensed
Intensive Care Coordination	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Intensive Home Based Services	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Therapeutic Foster Care	Only TFC Parents can use this code – see code description for further details										

Intensive Care Coordination (ICC)

Service Code: T1017ICC

ICC is a targeted case management service that facilitates assessment of, care planning for, and coordination of services for members of the Katie A. Subclass and those identified as Pathways to Well-Being eligible. ICC is similar to the activities routinely provided as Targeted Case Management (TCM), the difference being that ICC services must be delivered using a Child and Family Team (CFT) to develop and guide the planning and service delivery process for clients with more intensive needs and/or whose treatment requires cross-agency collaboration. Targeted Case Management services for Pathways/Subclass clients will be billed as ICC starting with the first Child and Family Team (CFT) meeting and thereafter.

One of the key components of ICC services is the development of a comprehensive care plan by the CFT. The care plan addresses and integrates the activities of all parties involved with the client. The care plan should ensure medically necessary services are provided to the client and family to successfully meet the child's mental health needs. If applicable, the care plan should also support a child's successful transition out of the child welfare or probation systems by addressing safety and permanency issues. The care plan will incorporate and align with the goals and objectives of the Mental Health Client Service Plan (MH CSP), as well as the child welfare case plan and/or the probation disposition report. During CFT meetings, action plans will be created that identify specific tasks for CFT members to accomplish as they develop and implement the care plan.

ICC activities may include the following interventions:

- Developing and maintaining a constructive and collaborative relationship among a client, his/her family or caregiver(s), other MH providers, and other involved child-serving systems to create a CFT;
- Care planning and monitoring to ensure that a care plan is aligned and coordinated across all involved systems to allow the client to be served in his/her community in the least restrictive setting possible;
- Ensuring services are provided that equip the parent/caregiver(s) to meet the client's mental health treatment and care coordination needs;
- Ensuring that medically necessary MH services included in client's care plan are effectively and comprehensively assessed, coordinated, delivered, transitioned, and/or reassessed as necessary in a way that is consistent with the full intent of the CPM;
- Providing active coordination of services and resources as required to meet the goals of the care plan; and
- Actively participating in the CFT planning and monitoring process to assure the care plan addresses or is refined to meet the MH needs of the client.

Billable Services Include:

- ✓ Facilitating or actively participating in a CFT meeting
- ✓ Assessing client's and family's needs and strengths (does not include intake assessment to determine if client meets medical necessity)
- ✓ Assessing the adequacy and availability of resources
- ✓ Gathering information from family and other members of the CFT
- ✓ Evaluating the effectiveness of previous interventions and activities
- ✓ Developing a care plan with specific goals, activities and objectives
- ✓ Supporting the active participation of the client and individuals involved in the service and clarifying each person's role
- ✓ Identifying the interventions/course of action targeted at the client's and family's assessed needs
- ✓ Monitoring to ensure that identified services and activities are progressing appropriately
- ✓ Changing and redirecting actions targeted at the client's and family's assessed needs, not less than every 90 days

- ✓ Developing transition plans for the client and family to foster long term stability including the effective use of natural supports and community resources
- ✓ Referral activities for programs, services, or resources approved by the client's CFT where connection to client's MH symptoms, impairment, and MH CSP objectives is clearly documented:
 - Linking client with medical, alcohol and drug treatment, social, or educational providers, programs, and/or services
 - Consultation and intervention on behalf of the client with Social Security, schools, social services and health departments, and other community agencies, in order to identify, assess, and mobilize resources to meet the client's needs
 - Providers may bill up to **30 minutes maximum** to complete referral forms for the purpose of obtaining services that would promote the client's mental health stability. Assisting the client with completing a form they could otherwise not complete on their own due to their mental health symptoms and functional impairments is also allowable

Non-Billable Activities Include:

- ✗ Activities that do not link to the goal of improving the client's MH condition
- ✗ Completing referral paperwork when the connection to client's MH symptoms and impairments is not clearly documented
- ✗ Completing purely clerical activities including, but not limited to: faxing, copying, leaving or listening to voicemails, reading or writing emails, scheduling appointments or CFT meetings, or filling out forms
- ✗ Writing court reports
- ✗ Completing reports to Adult Protective Services (APS), Child Protective Services (CPS), and/or law enforcement
- ✗ Transporting a client
- ✗ Providing a case management service to a member of the client's support system that has no direct link to the client's MH CSP goals, objectives, diagnosis, impairment, etc.

Progress Note Reminders:

- Targeted Case Management services for Pathways/Subclass clients will be billed as ICC starting with the first CFT meeting and thereafter
- Multiple MH providers may bill for a CFT meeting, however, each provider must demonstrate the unique purpose of his or her participation and the specific intervention(s) that s/he provided

A Good ICC Note Includes:

- An explanation of how the ICC intervention addresses the client's mental health functioning, functional impairments, and MH CSP objectives
- Documentation of the presence of a valid and current Release of Information if client's protected health information is disclosed
- Description of the connection of services to the CFT teaming process, as well as the Core Practice Model

- All team members in attendance and their relationship to the client when documenting a CFT meeting
- Relation of CFT meeting action plans to the client’s diagnosis, impairments, strengths, and MH CSP when documenting a CFT meeting

Lockouts & Other Limitations

Location of Client	ICC
Crisis Residential Facility	Permissible any time during a client’s stay in a Crisis Residential Facility.
Crisis Stabilization Unit	Permissible during the same time crisis stabilization is provided.
Fee-for-Service Hospital	Cannot be billed except for day of admission and for discharge planning during the 30 calendar days prior to scheduled discharge, for a maximum of 3 nonconsecutive periods of 30 calendar days or less, per continuous stay in the facility.
Group Home, or Short Term Residential Therapeutic Program (STRTP)	Permissible any time during a client’s stay in a group home or STRTP, per MHSUDS Information Notice No.: 17-055 dated 10/16/17.
Jail/Juvenile Hall	Cannot be billed.
Psychiatric Inpatient Hospital, Psychiatric Health Facility, or Psychiatric Nursing Facility	Permissible if provided solely for discharge planning during the 30 calendar days prior to discharge, for a maximum of 3 nonconsecutive periods of 30 calendar days or less, per continuous stay in the facility.

Intensive Home Based Services (IHBS)

Service Code: H2015IHBS

IHBS are mental health rehabilitation and collateral services provided to members of the Katie A. Subclass and those identified as Pathways to Well-Being eligible as medically necessary. IHBS are individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a client’s functioning, and are aimed at helping the client build skills necessary for successful functioning in the home and community, and improving the ability of the client’s family (or caregivers) to support the child/youth. The difference between IHBS and more traditional outpatient services (rehabilitation, collateral) is that the service is expected to be of significant intensity to address the mental health needs of the client, consistent with the MH CSP and the Core Practice Model (CPM), and will be predominantly delivered outside of an office setting, in the home, school, or community. IHBS services *must* be approved by the client’s Child and Family Team (CFT), and caregivers must agree to participate in home-based services. Rehabilitation and Collateral services for Pathways clients will be billed as IHBS once the Child and Family Team (CFT) has approved IHBS services and home-based services have begun.

IHBS activities may include the following interventions:

- Medically necessary, skill-based interventions for the remediation of behaviors or improvement of symptoms, including, but not limited to, the implementation of a positive behavioral plan and/or modeling interventions for the client's family and/or significant others to assist them in implementing the strategies;
- Development of functional skills to improve self-care, self-regulation, or other functional impairments by intervening to decrease or replace non-functional behavior that interferes with daily living tasks or avoid exploitation by others;
- Development of skills or replacement behaviors that allow the client to fully participate in the CFT and care plans, including, but not limited to the MH CSP and/or child welfare case plan or probation disposition report;
- Improvement of self-management of symptoms, including self-administration of medications, as appropriate;
- Education of the client and/or their family or caregiver(s) about, and how to manage, the client's mental health disorder or symptoms;
- Support of the development, maintenance, and use of social networks, including the use of natural and community resources;
- Support to address behaviors that interfere with:
 - achievement of a stable and permanent family life,
 - seeking and maintaining a job,
 - success in achieving educational objectives in an academic program in the community, or
 - transitional independent living objectives, such as seeking and maintaining housing and living independently

Billable Services Include:

- ✓ Assisting with a specific problem area related to client's diagnosis and impairments, such as teaching Activities of Daily Living (ADL) skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and/or medication compliance
- ✓ Working with client to identify obstacles (i.e., symptoms, problem behaviors) that are preventing client from meeting goals, and showing client how those obstacles might be overcome
- ✓ Helping strategize with client about what he or she can accomplish (i.e. prioritizing tasks)
- ✓ Teaching and reinforcing coping skills client has developed in therapy (e.g. relaxation skills, anger management)
- ✓ Consultation and training of the significant support person to assist client in better utilization of mental health services
- ✓ Providing support and psychoeducation to increase support person's understanding of the client's symptoms, strengths, barriers to progress, and paths to wellness and recovery
- ✓ Obtaining information relevant to the ongoing care of the client from an important person in the client's life
- ✓ Discussing with an important person in client's life (with Release of Information) how to help client overcome obstacles or how to support client with improvement in an area of functioning

- ✓ Helping family members who are part of the client's significant support team implement supportive strategies that will help the client meet his/her MH CSP goals and objectives and achieve a greater degree of wellness and recovery

Non-Billable Activities Include:

- ✗ Activities that do not link to the goal of improving the client's MH condition
- ✗ Completing purely clerical activities including, but not limited to: faxing, copying, leaving or listening to voicemails, reading or writing emails, scheduling appointments or CFT meetings, or filling out forms
- ✗ Transporting a client without simultaneously providing a billable service
- ✗ Providing a rehabilitation or collateral service to a member of the client's support system that has no direct link to the client's MH CSP goals, objectives, diagnosis, impairment, etc.
- ✗ Coordinating or linking with other providers/professionals (e.g. outside or adjunct agency staff, Child Welfare workers, school teachers, board and care operators, residential treatment/group home staff. See Intensive Care Coordination)
- ✗ Providing individual therapy for a client's parent or significant other
- ✗ Working with anyone else not perceived by the client as a member of the client's immediate family/support system

Progress Note Reminders:

- Rehabilitation and Collateral services for Pathways clients will be billed as IHBS once the CFT has approved IHBS services and home-based services have begun
- IHBS services are primarily provided in person and located in the home, school, or community, however, IHBS may be provided by phone with documented justification

A Good IHBS Note Includes:

- Description of skills practiced and how the intervention links back to the client's diagnosis and functional impairments
- A clear connection between the skills practiced with the client and the objectives on the Client Service Plan
- Information about the client's response to skill building, strategizing, and education during the meeting and how he or she will use this to improve functioning and reduce impairments
- Demonstration of how IHBS service activities can help improve functioning, reduce impairment, and lead to greater wellness and recovery
- Identification of people involved in the service and their role in the client's life, for whom you have a current Release of Information
- Documentation of the presence of a valid and current Release of Information, when warranted
- The training or psychoeducation provided to the significant support person
- How the client's mental health goals were addressed through IHBS support
- The response of those involved in the service to the mental health interventions
- Follow up plan, if needed

Lockouts & Other Limitations

Certain services may be part of the client's course of treatment, but cannot be provided during the same hours of the day that IHBS services are being provided to the client. These services include:

- Day Treatment Intensive
- Day Rehabilitation
- Group Therapy
- Therapeutic Behavioral Services (TBS)

Therapeutic Foster Care (TFC)

Service Code: S5145TFC

TFC is a short-term, intensive, highly coordinated, trauma-informed and individualized mental health service, provided by a TFC parent to a client under the age of 21 who has complex emotional and behavioral needs. A client receiving TFC services has been placed with a trained, intensely supervised, and supported TFC parent who meets both Resource Family Approval program standards and the required qualifications as a TFC parent. The TFC parent is working under the supervision and direction of a Licensed Mental Health Professional (LMHP) or a Waivered or Registered Mental Health Professional (WRMP) who is employed by a TFC Agency that has been certified as a Medi-Cal provider and has a contract with Solano County Behavioral Health for TFC. Only TFC parents may use the TFC billing code.

The TFC parent serves as a key participant in the therapeutic treatment process of the client. TFC is not intended to be a stand-alone service, and must be provided as part of a continuum of care with other SMHS, including ICC. TFC services *must* be approved by the client's Child and Family Team (CFT) and must be determined to be medically necessary because the client is at risk of losing his or her placement and because other intensive services have proven insufficient. TFC services will assist the client to achieve MH CSP goals and objectives, improve functioning and well-being, and help the client remain in a family-like home in a community setting, thereby avoiding residential, inpatient, or institutional care. TFC includes the provision of plan development, rehabilitation, and collateral SMHS by a TFC parent as a home-based alternative to high level care in institutional settings, such as group homes or Short Term Residential Therapeutic Programs (STRTPs). TFC may also be necessary when a client is transitioning from a residential, inpatient, or institutional setting, and ICC, IHBS, and other intensive SMHS will not be sufficient to stabilize the client in the community.

TFC activities may include the following interventions:

- Plan development (limited to when it is part of the CFT): The TFC parent as a member of the CFT will participate in care planning, monitoring, and review processes. The TFC parent will also observe, monitor, and alert the TFC Agency and members of the CFT about changes in the client's needs;
- Rehabilitation: The TFC parent will implement interventions, which include trauma-informed rehabilitation treatment strategies set forth in the client's MH CSP;
- Collateral: The TFC parent will meet the needs of the client in achieving his or her MH CSP by reaching out to significant support persons and by providing consultation and/or training for needed medical, vocation, or other services to assist in better utilization of SMHS by the client.

Billable Services Include:

- ✓ Actively participating in a CFT meeting for care planning, monitoring, and review
- ✓ Providing skills-based, medically necessary interventions, including coaching and modeling
- ✓ Providing skills training, including developing functional skills to improve self-care
- ✓ Providing interventions to improve self-management in areas including anger management, self-esteem, or peer relations
- ✓ Mentoring, consultation and/or training of significant support persons to assist the client in increasing resiliency, recovery, or improving utilization of services
- ✓ Mentoring, consultation and/or training of significant support persons to assist in better understanding of the client’s symptoms, strengths, barriers to progress, and paths to wellness and recovery

Non-Billable Activities Include:

- ✗ TFC services does not include reimbursement for the cost of room and board
- ✗ Foster care program-related services (e.g., assessing adoption placements, serving legal papers, home investigations, administering foster care subsidies)
- ✗ Parenting functions such as providing food or transportation
- ✗ Activities that have no link to the client’s MH CSP goals, objectives, diagnosis, or impairments
- ✗ Communication with significant support persons that does not focus on client’s treatment and mental health

Progress Note Reminders:

- The TFC parent must write and sign a progress note for each day of service; the progress note must meet Medi-Cal documentation standards and be written in BIRP format
- The TFC Agency’s licensed, waived or registered mental health professional must review and co-sign each progress note to indicate that service activities are appropriate and that documentation requirements are met

A Good TFC Note Includes:

- Observations of the client’s behavior for the day, including target behaviors as well as appropriate or positive behaviors and interactions the child engaged in
- The strategies used by the TFC parent to address target behaviors, based on proposed interventions identified in the MH CSP
- The client’s response to interventions, including the effectiveness of any coping strategies practiced

Lockouts & Other Limitations

Location of Client	TFC
Psychiatric Inpatient Hospital, Psychiatric Health Facility, or Psychiatric Nursing Facility	Cannot be billed while client is in one of these facilities except for the day of admission or discharge

Location of Client	TFC
Jail/Juvenile Hall	Cannot be billed
Group Home, or Short Term Residential Therapeutic Program (STRTP)	Cannot be billed except for the day of admission or discharge