Medi-Cal for Kids & Teens Provider Training

Medi-Cal for
Kids and Teens

January 2026

Today's Training

- **Goals & Purpose of Today's Training**
- **Training Modules**
  - **Module 1:** What is Medi-Cal for Kids & Teens and How Does it Work?
  - **Module 2:** Deep Dive into Behavioral Health Services, California Children's Services Program, and Skilled Nursing Services

Federal law enacted in 1967 established **Early and Periodic Screening, Diagnostic and Treatment (EPSDT),** which guarantees all medically necessary services to children and youth under age 21 enrolled in Medi-Cal. As of 2023, California refers to EPSDT as

Medi-Cal for Kids & Teens

Millions of Children in Medi-Cal Are Not Receiving Preventative Health Services

In 2019, the California State Auditor released a report highlighting the low rates of children's preventative health services in Medi-Cal. A follow-up audit in 2022 underscored that millions of Medi-Cal-enrolled children are still not receiving preventative services. In response, the Department of Health Care Services (DHCS) committed to developing a standardized provider training on Medi-Cal for Kids & Teens.

The 2019 California State Audit found:

- 2.4 million children enrolled in Medi-Cal did not receive required preventive services – roughly half of all children under age 21 in Medi-Cal
- Pre-pandemic, California ranked 40th nationwide for utilization of children's preventive services, or 10 percentage points below the national average

Since the COVID-19 pandemic, California's preventive services utilization has continued to decline:

1 in 2 children ages 12 – 21 received at least one annual well-care visit



22% of children under the age of 3 received a developmental screening



Less than half of children at age 13 were fully immunized



Goals of Medi-Cal for Kids & Teens Provider Training

The training aims to strengthen understanding and awareness of Medi-Cal for Kids & Teens among Medi-Cal managed care plan-enrolled providers and increase access to children's health services.



- California's managed care plans must ensure that all Medi- Cal licensed providers receive proper education and training regarding Medi-Cal for Kids & Teens at least every two years.
- More information on Medi-Cal for Kids & Teens for providers is available in the Information for Medi-Cal Providers resource document.

Medi-Cal for Kids & Teens Training Modules



Module 1: What is Medi-Cal for Kids & Teens and How Does it Work?



Module 2: Deep Dive into Behavioral Health Services, California Children's Services Program, and Skilled Nursing Services

In This Module You Will Learn:



- What is Medi-Cal for Kids & Teens
- What screening, diagnostic services, and treatment services are covered under Medi-Cal for Kids & Teens
- What the definition of "medical necessity" means for children enrolled in Medi-Cal
- What limitations can be placed on Medi-Cal for Kids & Teens services
- How you can help support access to required services for your patients
- Your role in informing children and families about Medi-Cal for Kids & Teens covered services

What is Medi-Cal for Kids & Teens?

- Requires comprehensive age-appropriate health care service be provided to all Medi-Cal enrolled children and you under age 21
- Requires preventative screening, diagnostic services, and treatment services
- Screenings, coverage requirements, and definition of medical necessity for children enrolled in Medi-Cal are more robust than that for adults' care

Goal of Medi-Cal for Kids & Teens

Ensure that children get the

Right Care

at the

Right Time

in the

Right Place

Medi-Cal for Kids & Teens Services Are Free for Most Children Under Age 21



- All medically necessary Medi-Cal for Kids & Teens preventative, screening, diagnostic, and treatment services for children and you are free for most children and youth under age 21
- Some youth between ages 18 and 20 enrolled in Medi-Cal may pay a "Share of Cost" for some treatment based on their income and family size. This is determined at the time of Medi-Cal eligibility. These youth are "carved out" of Medi-Cal managed care and receive services through fee-for-service.

Medi-Cal for Kids & Teens Periodicity Schedule

- Medi-Cal for Kids & Teens follows the **Bright Futures/American Academy of Pediatrics (BF/AAP) Periodicity Schedule.**
- The BF/AAP Periodicity Schedule is a schedule of screenings and assessments recommended at each well-child visit from infancy through adolescence.
- The most up to date BF/AAP Periodicity Schedule can be accessed online here.



Medi-Cal for Kids & Teens Periodic Screenings

Medi-Cal for Kids & Teens screening services are designed to identify health and developmental issues as early as possible.

Reimbursable Screening Services

Comprehensive health and developmental history	Comprehensive, unclothed physical exam, including nutritional, height/weight, and Body Mass Index assessment	Behavioral health screening, including depression screening and tobacco, alcohol, or drug use
Developmental screening for physical and mental health using standardized screening tools	Age-appropriate immunizations (based on the Bright Futures / American Academy of Pediatrics (BF/AAP) Periodicity Schedule and Advisory Committee on Immunization Practices (ACIP) Recommendations)	Age-appropriate laboratory tests, including blood lead screening test
Oral health screenings and referrals to a dentist (beginning by age 1 or eruption of first tooth)	Age-appropriate vision and hearing screenings	Health education and anticipatory guidance for child and caregiver



Any qualified Medi-Cal provider (acting within the scope of their practice) may conduct these screenings.

Screenings may be provided at physician offices and clinics, community health centers, local health departments, or schools



Families do not need to request these screenings, and prior authorizations are not permitted

Medi-Cal for Kids & Teens Screenings & Services

The following slides outline requirements for a subset of required screenings and services, including screening tools and billing codes.

Subset of Required Medi-Cal for Kids & Teens Screenings & Services	
Blood Lead Screening Services	Vision Screening Services
Developmental Screening Services	Hearing Screening Services
Autism Spectrum Disorder (ASD) Screening Services	Oral Health Screening Services
Depression Screening Services (for adolescents and postpartum individuals)	Adverse Childhood Experiences (ACEs)/Trauma Screening Services
Dyadic Services	Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT)

Blood Lead Screening Services (1 of 2)

Providers must perform blood lead screening tests at specific intervals and deliver anticipatory guidance to parents/caregivers that indicates children can be harmed by exposure to lead and are at risk of lead poisoning.

» **Anticipatory Guidance.** Providers must provide oral or written anticipatory guidance to parents or caregivers at each well-child visit starting at 6 months until 6 years of age; guidance must include information on:

- The harm of lead exposure to children (especially from lead-based paint and its dust) **and**
- The risk of lead poisoning from the time a child begins to crawl until 6 years of age

» **Periodicity Schedule.** Providers must order or perform blood lead screening tests for children at the following intervals:

- At 12 months and 24 months of age;
- In between 12 to 24 months of age if the child has no documented evidence of a blood lead screening test taken;
- In between 24 months to 6 years of age if the child has no documented evidence of a blood lead screening test taken;
- Any time a change in circumstances has put the child at risk; **or**
- If requested by the parent or caregiver

Blood Lead Screening Services (2 of 2)

Refugee Screening. Providers must follow the CDC Recommendations for Post-Arrival Lead Screening of Refugees, which states that all refugee children ages 0-16 or adolescents over age 16 with suspected lead exposure should be evaluated with a blood lead screening test

Lead Screening CPT Codes

» The following CPT codes may be used in the context of blood lead screening and counseling:

- 36415 – Collection of venous blood by venipuncture
- 36416 – Collection of capillary blood specimen (e.g. finger, heel ear stick)
- 83655 – Blood lead analysis

Optional Counseling Codes (use with caution):

- 99401- 99404 – Preventative medicine counseling (15-60 minutes)

These codes are not billable in conjunction with preventative health visit codes (e.g. 99381-99385). Their use should be limited to standalone counseling visits where lead exposure is the primary focus.

Note: Providers should follow Medi-Cal billing guidance and APL 20-016 for documentation and reporting requirements. Utilization of 99401-99404 for lead counseling is not required for compliance but may be used when appropriate.

See California Department of Public Health's (CDPH) Standard of Care Guidelines on Childhood Lead Poisoning for California Health Care Providers for more information

Developmental Screening Services

Providers must deliver developmental screenings at age-appropriate intervals at ages 9 months, 18 months, and 30 months per BF/AAP Periodicity Schedule, and when medically indicated.

- **Overview.** The developmental screening includes a comprehensive health and developmental history, including both physical and mental health development assessments, designed to identify if a child's motor, language, cognitive, social, and emotional development are on track and connect to services, if needed
  - **Billing Codes.** The CPT code for reimbursement is 96110; screenings can be provided twice a year for children ages 0 to 5
  - **Screening Tools.** Providers must use a standardized screening tool, with approved options including:
    - Ages and Stages Questionnaire (ASQ)
    - Ages and Stages Questionnaire (ASQ-3)
    - Battelle Developmental Inventory Screening Tool (BDI-ST)
    - Bayley Infant Neuro-developmental Screen (BINS)
    - Brigance Screens-II
    - Child Development Inventory (CDI)
    - Infant Development
    - Parents' Evaluation of Developmental Status (PEDS)
    - Parent's Evaluation of Developmental Status - Developmental Milestones (PEDS-DM)
- **Referrals to Regional Centers.** Providers should refer children to Regional Centers for services and supports that are needed because of a developmental disability



Supplemental Incentive Payment. Under Proposition 56, Medi-Cal reimburses providers a supplemental incentive payment of $59.90 for developmental screenings

Autism Spectrum Disorder Screening Services

Providers must perform autism spectrum disorder (ASD) screenings at 18 and 24 months, per the BF/AAP Periodicity Schedule, and when medically indicated.

- **Billing Codes.** Providers should use the developmental screening CPT code 96110 but must include the modifier KX
  - ASD and developmental screenings are reimbursable when performed on the same day at 18 months and when medically indicated
- **Screening Tool.** Providers must use a validated screening tool to screen for ASD, such as: MCHAT-R/F (ages 16 to 30 months old); SCQ (ages 4 years old and up); and STAT (ages 24 to 35 months old)
- **Services & Referrals.** Medi-Cal for Kids & Teens covers all medically necessary behavioral health treatment for eligible enrollees under 21 years of age regardless of ASD diagnosis
  - Behavioral health treatment services include applied behavioral analysis (ABA) and a variety of other evidence-based approaches that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction, and promote, and functioning
  - Providers should refer individuals to either their managed care plan or their local Regional Center to receive medically necessary behavioral health treatment services



Examples of behavioral health treatment services include behavioral interventions, cognitive behavioral intervention, comprehensive behavioral treatment, language training, modeling, natural teaching strategies, parent/guardian training, peer training, pivotal response training, schedules, scripting, self-management, social skills package, and story-based interventions.

Depression Screening Services

Depression Screening

- **Periodicity Schedule.** Providers must perform **depression screenings on children** ages 12 and older at every well-child visit
- **Billing Codes.** The HCPCS codes are G8431 (positive screening with follow-up plan) and G8510 (negative screening and no follow-up plan) may not be submitted more than once a year per child unless to correct or ameliorate a condition (see slides 27-29). Apply modifier EP for EPSDT services.

Postpartum Depression Screening at Infant Visits

- **Periodicity Schedule.** Providers may perform postpartum depression screenings **for the birthing parent** at up to four times during an infant's first year of life
  - BF/AAP Periodicity Schedule recommends this happens during the well-infant visits at 1, 2, 4, and 6 months of age
  - **Billing Processes.** These screenings must be billed to the infant's Medi-Cal ID regardless if the birthing parent is enrolled in Medi-Cal; if the infant's Medi-Cal eligibility has not been established during the first two months of life, the screening may be billed to the birthing parent's Medi-Cal ID
- **Billing Codes.** Providers must submit at least one claim with a diagnosis code if multiple depression screenings are performed for a single Medi-Cal member with HCPCS codes G8431 and G8510 in a year.

Screening Tools. Providers must use a validated depression screening tool for children and youth and pregnant or postpartum individuals, with options including the Patient Health Questionnaire (PHQ-9), Edinburgh Postnatal Depression Scale (EPDS), and Beck Depression Inventory (BDI)

Dyadic Services

As of January 2023, Medi-Cal covers dyadic and family therapy services, which include integrated physical and behavioral health screenings and services for the child and their parent/caregiver or whole family, not just the child who is the identified patient. Dyadic services involve simultaneous treatment for the child and parent/caregiver, with studies showing significant improvements in child behavior issues and increases in positive parent/child attachment.



Dyadic Services for Children ages 0 to 20

Billing Codes. Medi-Cal reimburses a number of dyadic services for recipients ages 0 to 20 years, when billed to the child's Medi-Cal ID. The U1 modifier is required to designate dyadic services.

- Dyadic Behavioral Health (DBH) Well-Child Visits (H1011)
- Dyadic Comprehensive Community Support Services (H2015)
- Dyadic Psychoeducational Services (H2027)
- Dyadic Family Training and Counseling for Child Development (T1027)

Dyadic Services for Parent/Caregivers Billing Codes.

Providers may also deliver dyadic caregiver services at a well child visit in which the caregiver(s) are present. The U1 modifier is required to designate dyadic services.

- Brief emotional/behavioral assessment (96127)
- ACE screening (G9919, G9920)
- SABIRT (G0442, H0049, H0050)
- Depression screening (G8431, G8510)
- Health behavior assessments and interventions (96156, 96167, 96168, 96170 and 96171)
- Psychiatric diagnostic evaluation (90791, 90792)
- Tobacco cessation counseling (99406, 99407)

See the Non-Specialty Mental Health Services Manual for more information on dyadic services **billing codes, modifiers, and screenings**

Vision and Hearing Screening Services

Providers must deliver vision and hearing screening for all children and youth under age 21 per BF/AAP Periodicity Schedule to identify need for glasses, contacts, hearing aids, cochlear implants, or other concerns.

Vision Screening

- **Periodicity Schedule.** Providers must conduct vision screenings at years 3, 4, 5, 6, 8, 10, 12, and 15, with risk assessments conducted at other ages
- **Screening Tools.**
  - Providers may use instrument-based screening to assess risk at ages 12 and 24 months and at well child visits at ages 3 through 5 years
  - Providers may deliver a visual acuity screening starting at ages 4 and 5 years, as well as in cooperative 3-year-olds
- **Billing Codes.** Reimbursement codes include CPT 99173*, 99381 thru 99385 and 99391 thru 99395

*For school-based enrolled Medi-Cal providers only

Hearing Screening

- **Periodicity Schedule.**
  - Providers must confirm the initial newborn screening was completed, verify results, and follow up as appropriate
  - After the newborn screening, providers must conduct hearing screenings at years 4, 8, 10, 13, 16, and 20, with risk assessments conducted at other ages
- **Billing Codes.** Reimbursement codes include CPT 92551 (screening test, pure tone, air only) and 92552 (pure tone audiometry [threshold]; air only) with ICD-10-CM diagnosis codes Z00.121, Z00.129, Z01.10, or Z01.11 available for hearing screenings

Oral Health Screening & Assessment Services

Providers must perform oral health screening and assessment services and ensure children ages 6 years and under are referred to a Medi-Cal Dental provider. Primary care providers have an important role in ensuring oral health care, guidance, and education are provided to children and families.

- **Oral Health Screening Schedule.**
  - Primary care providers must conduct an oral health assessment at minimum at the 6, 9, 12, 18, 24, and 30 month well-child visits, as well as annually starting at age 3 and up *or* sooner at eruption of first tooth, should that occur first
  - On this same schedule, primary care providers must assess whether the child has a dental home. If no dental home is identified, then providers must refer the child to a Medi-Cal dental provider
- **Billing Codes.** Reimbursement codes CPT 99381 – 99383 and 99391 – 99393 for oral health risk assessment
- **Fluoride Varnish.** Once teeth are present, fluoride varnish should be applied to all children every 3 – 6 months through age 5 in the primary care or dental office based on caries risk
  - Reimbursement codes HCPCS D1206 and CPT 99188 for fluoride varnish, up to three times in 12-month period
- **Fluoride Supplementation.** If a child's primary water source does not contain fluoride, primary care providers must consider providing fluoride supplementation to children ages 6 months through 16 years of age



Dental providers are responsible for providing dental care that goes beyond oral health assessments (such as dental cleanings and tooth extractions). Medi-Cal managed care providers are responsible for providing referrals to a dental provider in the child's network, which will either be Dental Fee For Services (in most California counties) or Dental Managed Care (in Sacramento and Los Angeles Counties).

ACEs/Trauma Screening Services

Providers may conduct adverse childhood experiences (ACEs) screenings for all children and youth under age 21. ACEs screenings are not currently included in the BF/AAP Periodicity Schedule but are encouraged through the California Surgeon General's ACEs Aware campaign and are reimbursable.

- **Recommended Schedule.** Providers may conduct ACEs screenings once per year, per child
  - ACEs "scores" are designated as high risk for toxic stress if a child's ACEs score is 4 or greater (HCPCS G9919) or low risk for toxic stress if the ACEs score is between 0 and 3 (HCPCS G9920)
- **Screening Tool.** Providers must use the validated PEARLS screening tool for ages 0 – 19 years for ACEs screening
- **Provider Training.** Providers must complete and attest to having completed the ACEs Aware Training in order to be eligible to receive the incentive payment (see box below)
- **Referrals.** Providers who conduct ACEs screenings must provide children with appropriate referrals when necessary for diagnosis and treatment without delay



Supplemental Incentive Payment. Under Proposition 56, Medi-Cal reimburses providers *who completed and attested to the ACES Aware training* with a supplemental incentive payment of $29.00 for trauma screenings

Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT)

Providers must provide SABIRT screening and services to children ages 11 years and older with a potential substance use disorder (SUD).

- **Screening.**
  - Validated screening tools for children/adolescents: Parents, Partner, Past, and Present (4Ps) and Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT)
  - **Billing Codes.** Reimbursement codes HCPCS G0442 for alcohol use screening and H0049 for drug use screening
    - If using CRAFFT, which is for alcohol and drug use screening, providers can bill both G0442 and H0049
- **Brief Assessment.** If a screening is positive, then providers should assess whether the disorder is present.
  - Validated assessment tools: Drug Abuse Screening Test (DAST-20) and Alcohol Use Disorders Identification Test (AUDIT)
- **Brief Interventions & Referral to Treatment.** If a brief assessment reveals alcohol or drug misuse, providers can conduct brief interventions, which can include alcohol misuse counseling and discussing and agreeing on plans for follow-up, including referral to other treatment if indicated.
  - **Billing Codes.** Reimbursement code HCPCS H0050 for alcohol and/or drug brief intervention services
- **Provider Type.** SABIRT services are reimbursable to physicians, physician assistants, nurse practitioners, certified nurse midwives, licensed midwives, licensed clinical social workers, licensed professional clinical counselors, psychologists, and licensed marriage and family therapists
- **Documentation Requirements.** The provider must include in the child's medical records:
  - The service provided (e.g., screen and brief intervention);
  - The name of the screening and/or assessment tool and scores; and
  - If a referral to an alcohol or SUD program was made

Initial Health Appointment

Previously called the "Initial Health Assessment (IHA)," the Initial Health Appointment (IHA) is a Medi-Cal managed care requirement for adults and children to ensure new members receive a comprehensive assessment by a primary care provider.

- The IHA consists of a history of the member's physical and behavioral health, identification of risks, assessment of need for preventive screens or services and health education, and the diagnosis and plan for treatment of any diseases
- Providers must conduct the IHA within **120 days of a child's enrollment** in a managed care plan (or within the BF/AAP Periodicity Schedule timeline for children ages 18 months or younger, **whichever is sooner**)
  - If the first 120 days of a child's enrollment in a managed care plan falls within the timing of a child's scheduled well-child visit according to the BF/AAP Periodicity Schedule, the child's well-child visit will serve as the IHA
  - IHA cannot be delayed beyond the first 120 days of a child's initial enrollment in order to coincide with a scheduled well-child visit according to the BF/AAP Periodicity Schedule that is later than 120 days from enrollment; an earlier, separate IHA will be indicated in this case
- Each managed care plans' processes and policies are different, but managed care plans should support providers in helping to schedule an appointment to conduct the IHA within the required time period

As Needed Screenings (1 of 2)

While regular (periodic) screenings are required, additional screenings must be done any time when medically necessary to assess diagnoses between regularly scheduled screenings. These as needed screenings are called "interperiodic screenings."



- As needed screenings **may not** be limited in number nor require prior authorization
- Medical necessity of as needed screenings may be determined by the child's physician; dentist; or a health, developmental, or educational professional who comes into contact with the child
- A parent or caregiver can request a child receive an as needed screening outside of the BF/AAP Periodicity Schedule
- As needed screenings should be billed using the appropriate preventive medicine CPT code and ICD-10 CM diagnosis code Z00.8 (encounter for other general examination); the reason for the as needed screening must be documented in the medical record

As Needed Screenings (2 of 2)

Examples of As Needed Screenings (not limited to):



A child receiving **foster care** receives a medical history and physical examination



A child joining a **sports** team or camp receives a pre-participation medical history and physical examination



A child with a history of **perinatal problems** receives additional screenings



A child enrolling in **school** receives a pre-participation medical history and physical examination



A child with a history of **developmental disability** receives additional screenings



A child or their parent/caregiver or guidance receives additional **anticipatory guidance**



A child entering California as a **refugee** receives a medical history and physical examination

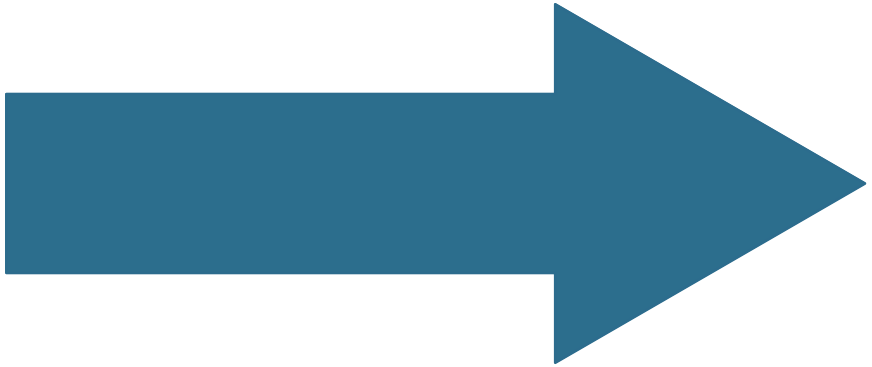
Medi-Cal for Kids & Teens Diagnostic Services



Screening Services

Screenings are designed to identify health and developmental issues as early as possible

When diagnostic and/or treatment services are indicated as a result of a screening, providers must take all reasonable steps, including follow-up, to ensure enrollees receive medically necessary diagnostics and treatment **no later than 60 days after screening**





Diagnostic Services

A child's diagnosis may be provided by a physician or other qualified practitioner

Medical Necessity (1 of 2)

» Medi-Cal for Kids & Teens **defines medical necessity broader for children and youth enrolled in Medi-Cal compared to adults.** If a service is medically necessary and is included within any of the mandatory or optional categories of Medicaid-covered services listed in Section 1905(a) of the Social Security Act, then it must be provided to the child, even if the service is not included in the Medi-Cal State Plan.

» Under Medi-Cal for Kids & Teens, medical necessity is defined under federal and state requirements as services **correcting or ameliorating conditions, defects, and physical and mental illnesses.**

» **A service need not cure a condition** in order to be covered under Medi-Cal for Kids & Teens. Services that **maintain (by preventing a condition from worsening or preventing additional health problems) or improve a child's condition** are covered because they **"ameliorate"** a condition.

Medical Necessity (2 of 2)

- Medical necessity must be **determined on a case-by-case, individual basis** and **consider all aspects of the child's needs**

- Providers play a significant role in medical necessity determinations, as they are responsible for **justifying why a service is medically necessary for a child** to their contracted managed care plan

- DHCS and its managed care plans **may require prior authorization** in order to safeguard against unnecessary use of services
  - Prior authorization **cannot delay or deny** medically necessary services
  - Limits based on a monetary cap or budgetary constraints **may not be imposed**; for example, if it is medically necessary for a child to have 20 hours per week of private duty nursing, then the managed care plan cannot limit the service to 10 hours per week

- California's managed care plans **may not use a definition of medical necessity that is more restrictive** than the federal definition, which is the same definition as in California law

Medical Necessity Review Criteria

What is a medically necessary service per Medi-Cal for Kids & Teens?

Medically Necessary

- ✓ Service is reasonable, appropriate, and effective method to correct, maintain, or ameliorate the child's medical needs
- ✓ Service is in accordance with current medical standards or practices
- ✓ Service's scope (e.g., number of hours of skilled nursing care) is sufficient to address the child's needs
- ✓ Service is necessary to ensure for a safe environment for the child to ameliorate a given condition

Not Medically Necessary

- ✓ Service is experimental or investigational (considered on a case-by-case basis)
- ✓ Service is primarily for caregiver convenience (e.g., DME duplicated to be provided at divorced parents' homes)
- ✓ Service is more expensive than an equally effective and less expensive, available service; however, cost is not a basis for determining a service should not be provided



If the service is determined to be medically necessary, the service must be covered if it can be covered under Medicaid, even if it is not in the Medi-Cal State Plan or not provided to adults, or if the child does not have a diagnosis

Second Opinions



- If a provider requests a service for a child that is **denied** by the managed care plan, then the provider can request a **second opinion** from a qualified health professional
- Managed care plans must permit second opinions through their **Utilization Management Program** that ensures appropriate processes are used to review and approve the provision of medically necessary covered services in Medi-Cal Managed Care

Medical Necessity Review Criteria: Occupational Therapy Example



- An 8-year-old enrolled in a Medi-Cal managed care plan receives a periodic developmental screening at their well-child checkup that indicates a developmental delay
- The pediatrician prescribes the child occupational therapy services
- The pediatrician submits a prior authorization request for occupational therapy to the Medi-Cal managed care plan
- The managed care plan conducts medical necessity review and determines the occupational therapy services are **not** medically necessary
- The pediatrician requests a second opinion through the managed care plan's Utilization Management Program with another qualified health professional
- The other qualified health professional agrees with the pediatrician's assessment that the therapy is medically necessary for the child and submits results to the managed care plan
- The managed care plan reviews the second opinion and determines the occupational therapy services are medically necessary
- The pediatrician refers the child to a licensed occupational therapist and provides follow-up care

Settings for Medi-Cal for Kids & Teens Services: School-Based Services

- Medi-Cal-enrolled children and youth under age 21 can receive the following Medi-Cal covered services from schools:
  - Nutritional assessments and counseling treatments
  - Vision assessments and screenings
  - Physical, respiratory, occupational, and speech- language therapy
  - Audiology assessment, treatments, and hearing screening tests
  - Psychology and counseling services and psychosocial assessments
  - Orientation and mobility services
  - Developmental assessments
  - Specialized medical transportation
  - Health education and anticipatory guidance
  - School health aide services (administration of specialized physical health care services and assistance with Activities of Daily Living)



Settings for Medi-Cal for Kids & Teens Services: Out-Of-State Services

- DHCS and its managed care plans must cover out-of-state services if the service would be covered in-state, and:
  - Service is required because of an emergency;
  - The child is out of state and the child's health would be endangered if they were required to travel to their home state;
  - Service is more readily available in another state; **or**
  - The child lives in an area that often utilizes services in another state (i.e., if area borders another state)



Settings for Medi-Cal for Kids & Teens Services: Telehealth Modality

- Medi-Cal covered benefits or services may be provided via telehealth if:
  - The treating provider believes the benefits or services are clinically appropriate to deliver via telehealth;
  - Benefits or services meet procedural definition and components of CPT or HCPCS codes and Medi- Cal provider manual guidelines; **and**
  - Benefits or services meet all laws regarding confidentiality and a patient's right to their medical information
- Benefits or services may be delivered via synchronous video, synchronous audio-only, or asynchronous store and forward, so long as those services meet the standard of care and billing code requirements that apply to in-person service. Include the following modifiers when billing for services delivered via telehealth:
  - Synchronous video: 95
  - Synchronous audio-only: 93
  - Asynchronous store and forward: GQ
- Medi-Cal enrolled children or youth may request or decline delivery of services via telehealth modality



Required Services to Support Access (1 of 2)

Necessary Transportation To and From Appointments

- Providers must offer and assist with arranging non-emergency medical transportation (NEMT) and non-medical transportation (NMT) so children/youth under age 21 can receive Medi-Cal for Kids & Teens services
  - **NEMT** is transportation by ambulance, wheelchair van, or litter van for children whose medical and physical condition does not allow them to travel by public or private transportation
    - Providers must submit a Physician Certification Statement (PCS) form to the managed care plan for NEMT prior authorization
  - **NMT** is private or public transportation; families or the child/youth will need to attest to their provider verbally or in writing that they have an unmet transportation need and all other currently available resources have been reasonably exhausted
    - Providers need to confirm with the managed care plan if prior authorizations are required for NMT services, as it is up to the managed care plan to determine
  - Families or the child/youth may request or refuse transportation assistance at any time

Related Travel Expenses

- California's managed care plans must cover related travel expenses for medically necessary services at the child/youth's request, including the cost of meals and lodging for a child and parent, caretaker, relative, friend, or attendant for the purpose of obtaining needed medical care

Providers can direct families to the **Medi-Cal Member Help Line at 1-800-541-5555 or their Medi-Cal Managed Care Plan** for help accessing transportation and travel supports

Required Services to Support Access (2 of 2)

Language Assistance

- Managed care plans must provide **oral interpretation** for any non-English speaking family or child/youth, free of charge, at all medical encounters (such as an outpatient visit) and certain non-medical encounters (such as scheduling appointments)
- **Sign language interpreter services** must also be provided during all medical and certain non-medical encounters
- Managed care plans must **translate the member handbook and provider directory** into prevalent non-English languages when at least 3,000 or 5% of the managed care plan's members speak a non-English language, whichever is lower
  - The provider directory must include **cultural and linguistic capabilities of each provider**, including languages (including ASL) offered by the provider or a skilled medical interpreter at the provider's office, or access to language line interpreters
  - Families, children and youth, and providers can call the **Office of Civil Rights at (916)-440-7370, 711 (California State Relay) or the Medi-Cal Member Help Line at 1-800-541-5555** for assistance accessing language services
- Managed care plans must provide **alternative formats of the member handbook; provider directory; and dental, termination, and appeal notices** such as braille, audio format, large print (no less than 20-point Arial font), and accessible electronic format (e.g., data CD)

Appointment Scheduling Assistance

- Providers must offer and provide, as requested, assistance with scheduling appointments for Medi-Cal for Kids & Teens services

Informing Families of Medi-Cal for Kids & Teens Services

Providers play an important role in communicating about Medi-Cal for Kids & Teens to children and families. A combination of face-to-face, oral, and written communication is recommended. Providers must inform all Medi-Cal eligible families of the services available to them under Medi-Cal for Kids & Teens, including:

- Benefits of preventive health and dental care
- Tips and information for choosing a health or dental care provider
- Nature and scope of Medi-Cal for Kids & Teens medical and dental services
- Appointment scheduling and transportation assistance availability
- Need for prompt diagnosis of suspected defects, illnesses, diseases or other conditions
- Availability of treatment for problems diagnose during screening
- Referrals to other providers for additional services not offered
- Ability to ask for and receive services, even if the services were initially denied

DHCS and its managed care plans must identify children that are underutilizing Medi-Cal for Kids & Teens screenings and preventive services and ensure outreach to these children

Medi-Cal for Kids & Teens Enrollee Brochures

DHCS has developed brochures for children and families enrolled in Medi-Cal to increase knowledge and awareness of Medi-Cal for Kids & Teens. There are two brochures: (1) children ages 11 and under and (2) children and youth ages 12 through 20).

- Brochures are available in multiple languages here for providers to print and share in offices
- Providers are encouraged to print and share brochures broadly with families enrolled in Medi-Cal
- Managed care plans will distribute these brochures to families with children on an annual basis



What happens at your child's check-up?

Your child's provider will:

- Do a physical exam
- Ask about your family's health history
- Give recommended shots, when needed
- Talk about dental health and, when needed, give your child fluoride varnish and fluoride supplements, and help in finding a dentist
- Check your child's hearing and vision
- Discuss important health topics such as development, behaviors, your and your child's mental health, nutrition, sleep, safety, and protecting skin from the sun

Your child's provider will check for:

- **Developmental milestones**
- **Lead poisoning**
- **Anemia,** if at risk
- **Autism**
- **Depression screening** in new mothers
- **Anxiety**
- **Tuberculosis (TB),** if at risk
- **Cholesterol,** if at risk
- **Other health issues** or concerns you have

February 2023 for children from birth to age 12

If you have questions or want to learn more

Your Medi-Cal managed care plan
The phone number is on your plan ID card and your plan's website
Or go to www.dhcs.ca.gov/mmchpd

Medi-Cal Member Help Line
Call **1-800-541-5555** (TDD 1-800-430-7077)
Or go to www.dhcs.ca.gov/myMedi-Cal

Medi-Cal Dental
Call Smile, California at **1-800-322-6384** (TTY 1-800-735-2922)
Or go to smilecalifornia.org or www.dhcs.ca.gov/MCP

Specialty Mental Health
Call **1-888-452-8609**
To ask about services for a serious mental health condition, contact your county Mental Health Plan at www.dhcs.ca.gov/CMHP

Alcohol or drug use
Call the Department of Health Care Services (DHCS) Substance Use Resource Center 24/7 at **1-800-879-2772**
Or go to www.dhcs.ca.gov/SUD-NETRL

Crisis support
Call the National Suicide Prevention Line at **988**
Or call **1-833-317-HOPE** (4673)
For live CalHOPE crisis counseling, go to www.calhopeconnect.org

Your rights and responsibilities
Call **1-888-452-8609**

DHCS
www.dhcs.ca.gov/services/pages/EPSDT.aspx

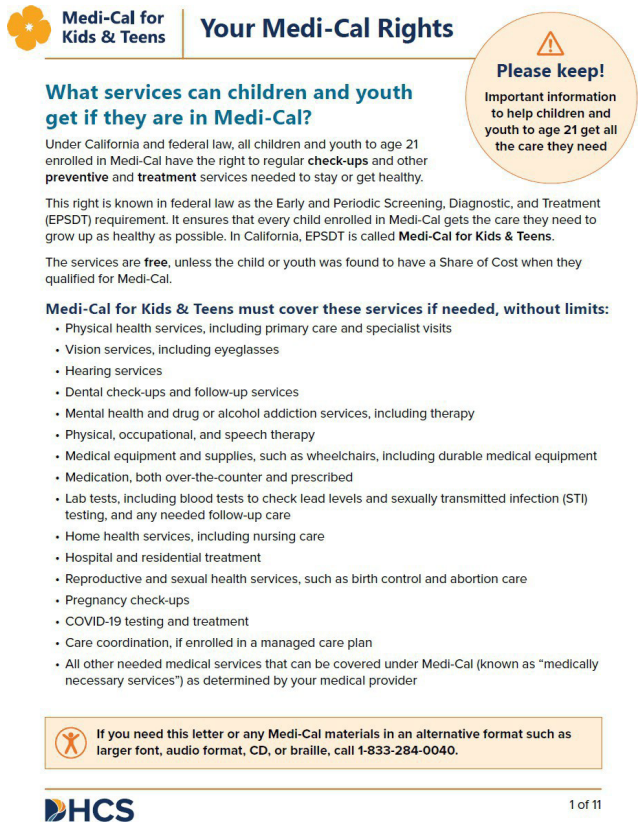
Medi-Cal for Kids & Teens

Preventive and treatment services from birth to age 21

Medi-Cal for Kids & Teens
Your Medi-Cal Rights Letter

DHCS has developed a letter for children and families enrolled in Medi-Cal outlining their rights in accessing Medi-Cal for Kids & Teens, as well as what to do when care is denied, delayed, reduced, or stopped.

- The letter is available in multiple languages here for providers to print and share in offices
- Providers are encouraged to print and share the letter broadly with families enrolled in Medi-Cal
- Managed care plans will distribute the letter to families with children on an annual basis



Medi-Cal for Kids & Teens | Your Medi-Cal Rights

Please keep!
Important information to help children and youth to age 21 get all the care they need

What services can children and youth get if they are in Medi-Cal?

Under California and federal law, all children and youth to age 21 enrolled in Medi-Cal have the right to regular **check-ups** and other **preventive** and **treatment** services needed to stay or get healthy.

This right is known in federal law as the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirement. It ensures that every child enrolled in Medi-Cal gets the care they need to grow up as healthy as possible. In California, EPSDT is called **Medi-Cal for Kids & Teens**.

The services are **free**, unless the child or youth was found to have a Share of Cost when they qualified for Medi-Cal.

Medi-Cal for Kids & Teens must cover these services if needed, without limits:

- Physical health services, including primary care and specialist visits
- Vision services, including eyeglasses
- Hearing services
- Dental check-ups and follow-up services
- Mental health and drug or alcohol addiction services, including therapy
- Physical, occupational, and speech therapy
- Medical equipment and supplies, such as wheelchairs, including durable medical equipment
- Medication, both over-the-counter and prescribed
- Lab tests, including blood tests to check lead levels and sexually transmitted infection (STI) testing, and any needed follow-up care
- Home health services, including nursing care
- Hospital and residential treatment
- Reproductive and sexual health services, such as birth control and abortion care
- Pregnancy check-ups
- COVID-19 testing and treatment
- Care coordination, if enrolled in a managed care plan
- All other needed medical services that can be covered under Medi-Cal (known as "medically necessary services") as determined by your medical provider

If you need this letter or any Medi-Cal materials in an alternative format such as larger font, audio format, CD, or braille, call 1-833-284-0040.

DHCS 1 of 11

Test Your Learning

- Can maternal depression screenings be provided during an infant's well-child visit?
- Can providers support children and families in obtaining transportation to a medical appointment?
- A child with a developmental disability needs additional screenings outside of the Medi-Cal for Kids & Teens Periodicity Schedule. Are these additional screenings covered by Medi-Cal?
- If a child breaks their glasses, can they get a new pair?
- If a child needs 10 hours of home health services but their Medi-Cal managed care plan only approved 8 hours, how can the provider get the decision reviewed?
- What age does Medi-Cal for Kids & Teens apply to – up to age 18 or 21?

Medi-Cal for Kids & Teens Training Modules



Module 1: What is Medi-Cal for Kids & Teens and How Does it Work?



Module 2: Deep Dive into Behavioral Health Services, California Children's Services Program, and Skilled Nursing Services

In This Module You Will Learn…



- What are Medi-Cal for Kids & Teens covered mental health services and SUD services
- How non-specialty mental health and specialty mental health differ from each other in Medi-Cal
- Which children are eligible for California Children's Services (CCS) or CCS Whole Child Model (WCM) and why
- How children can qualify for Medi-Cal for Kids & Teens covered skilled nursing services

Mental Health Services

Medi-Cal for Kids & Teens covers all medically necessary mental health services for children and youth under age 21 enrolled in Medi-Cal. There are two different systems that the State leverages to deliver mental health services depending on the child and youth's level of need, including:



Non-Specialty Mental Health Services (NSMHS)

» **Managed care plans** are responsible for providing medically necessary NSMHS for children and youth under the age of 21

» NSMHS are **"carved in"** to Medi-Cal Managed Care

Specialty Mental Health Service (SMHS)

» **County mental health plans** are responsible for providing medically necessary SMHS for children and youth under the age of 21

- If a child/youth meets the criteria for SMHS, then they should be receiving any SMHS from the mental health plan, except in cases where the No Wrong Door policy applies (see slide 45))

» SMHS are **"carved out"** of Medi-Cal Managed Care



Children and youth under age 21 do **not** require a diagnosis in order to receive mental health services.

Mental Health Services Screening and Transition Tools

- Providers are NOT required to use the **Youth Screening Tool for Medi-Cal Mental Health Services** for children and youth under age 21 who are not currently receiving mental health services and who contact the Medi-Cal managed care plan or county mental health plan directly seeking mental health services

- Providers are required to use the **Transition of Care Tool for Medi-Cal Mental Health Services** to ensure enrollees who are receiving mental health services from one delivery system receive timely transition of care referrals or services referrals to their managed care plan or county mental health plan



- Both county mental health plan and managed care plan providers will leverage this tool statewide to better identify appropriate behavioral health delivery systems and services that are child and family-centered

No Wrong Door Policy

DHCS implemented a "No Wrong Door" policy in July 2022 to ensure enrollees receive mental health services without delay regardless of where they initially seek care.

Clinically appropriate NSMHS and SMHS are covered and reimbursable even when:



- Services are provided **prior to determination of a diagnosis**, during the assessment period, or **prior to determination of whether NSMHS or SMHS access criteria are met**;
- Services are not included in an **individual treatment plan**; *(currently only applies to NSMHS; guidance forthcoming for SMHS)*
- The child has a **co-occurring mental health condition and SUD**; or
- NSMHS and SMHS services can be **provided concurrently**, if the mental health plan and managed care plan coordinate to provide the services and ensure they are not duplicated (each plan would only be responsible for the services they are providing). See the No Wrong Door for Mental Health Services Webinar (slide 17) for more information regarding providing concurrent services.

Non-Specialty Mental Health Services (NSMHS)

NSMHS (formerly known as Mild to Moderate services) include a variety of behavioral interventions that promote the functioning of children and youth and prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction. Managed care plans must provide or arrange all medically necessary NSMHS for children and youth under age 21 regardless of their level of distress or impairment, or the presence of a diagnosis.

- **NSMHS include:**
  - Mental health evaluation and treatment, including individual, group and family psychotherapy
  - Dyadic services for children and their caregiver(s)
  - Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition
  - Outpatient services for purposes of monitoring drug therapy
  - Psychiatric consultation
  - Outpatient laboratory, drugs (not including outpatient pharmacy benefits covered under Medi-Cal Rx), supplies, and dietary supplements (e.g., folic acid, vitamin D, vitamin B12)
- **Provider types include:**
  - Licensed Clinical Social Worker
  - Licensed Professional Clinical Counselor
  - Licensed Marriage and Family Therapist
  - Licensed Psychologist
  - Associate provider types may render services under a supervising clinician
  - Psychiatric Physician Assistant
  - Psychiatric Nurse Practitioner
  - Psychiatrist (as consistent with the practitioner's training and licensing requirements)

For more information, please review the Non-Specialty Mental Health Services: Psychiatric and Psychological Services Provider Manual

County Specialty Mental Health Services

Each county mental health plan must provide or arrange all medically necessary SMHS for children and youth under age 21 enrolled in Medi-Cal who require more intensive mental health services.

County mental health plans must make individualized determinations of each child's need for SMHS. Examples include, but are not limited to:

- Intensive Care Coordination (ICC) (e.g., targeted case management for children in SMHS)
- Intensive Home-Based Services (IHBS) (e.g., interventions designed to correct or ameliorate conditions that interfere with functioning, and improve the family's ability to help the child successfully function at home/school/community)
- Therapeutic Foster Care (TFC) (e.g., short-term, trauma-informed, intensive SMHS for children with complex emotional and behavioral needs; in TFC, children are placed with trained and intensely supervised TFC parents)
- Therapeutic Behavioral Services (TBS) (e.g., short-term, intensive services for children with a SED)
- Psychiatric Health Facility Services and/or Inpatient Hospital Services (e.g., 24-hour inpatient care)
- Crisis Intervention, Stabilization, and/or Residential Services (e.g., community-based crisis intervention, short-term)
- Day Treatment Intensive and/or Rehabilitation Services (e.g., group therapy, skill building groups, short-term)
- Peer Support Services (optional)
- NSMHS- if a child meets the criteria for SMHS, then they may be receiving NSMHS from the Managed Care Plan, where the No Wrong Door policy applies (see slide 45)



SMHS may be provided during an assessment period for the child prior to the determination of a diagnosis or whether SMHS access criteria are met (see next slide for access criteria).

SMHS Access Criteria

For more information, please review BHIN 21-073

Covered SMHS shall be provided to children and youth who **meet either of the following criteria, (1) or (2) below:**

1. The child is at high risk for a mental health disorder due to experience of trauma (i.e., scores in the high-risk range under a trauma screening tool, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness)

OR

2. The child meets both requirements in a) and b), below:
   a) The child has at least **one** of the following:
      i. A significant impairment
      ii. A reasonable probability of significant deterioration in an important area of life functioning
      iii. A reasonable probability of not progressing developmentally as appropriate
      iv. A need for SMHS, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide

   AND

   b) The child's condition as described in (2) above is due to one of the following:
      i. A diagnosed mental health disorder
      ii. A suspected mental health disorder that has not yet been diagnosed
      iii. Significant trauma placing the child at risk of a future mental health condition, based on the assessment of a licensed mental health professional

Substance Use Disorder Services (1 of 2)

Medi-Cal for Kids & Teens covers all medically necessary substance use disorder (SUD) treatment, such as outpatient care, residential treatment services, and withdrawal management. SUD services are primarily provided through DMC or DMC-ODS programs, depending on the county, and some SUD services are provided by managed care plans.



SUD treatment services are provided to eligible Medi-Cal enrollees, including children and youth under age 21, via county-run **Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS)** programs:

- Counties have the option to participate in the DMC-ODS program and provide an expanded array of SUD treatment services to Medi-Cal enrollees
- All counties, regardless of their participation in DMC-ODS, are required to provide all applicable SUD services needed to correct or ameliorate health conditions that are coverable under Medi-Cal for Kids & Teens

Substance Use Disorder Services (2 of 2)

Though most SUD services are provided via DMC or DMC-ODS for children and youth, managed care plan providers must provide:

- SABIRT screening (see slide 22) to children starting at age 11 who are at risk of developing a SUD
- Early intervention SUD services for children and youth determined to be at risk of SUD (e.g., any service component covered under the outpatient level of care)
- Medications for Addiction Treatment (MAT) available in primary care, inpatient hospital, and emergency departments
- Emergency services to stabilize the child (including voluntary inpatient detoxification)



Some children may qualify for both SMHS and SUD services if they have a co-occurring SUD and mental health condition. **Providers are required to coordinate and collaborate across delivery systems** to ensure clinical integration between county mental health plans, DMC or DMC-ODS counties, and managed care plans, and to ensure non-duplicative services

Mobile Crisis Services

Medi-Cal for Kids & Teens covers qualifying mobile crisis services, including an initial face-to-face crisis assessment, crisis response and stabilization, crisis planning, referrals to ongoing services and supports, and follow-up. Mobile crisis services offer community-based interventions to individuals experiencing a mental health or substance use crisis and are available to Medi-Cal enrollees 24 hours a day, 365 days a year.

- Crisis intervention and habilitation services, including when delivered in a mobile modality, are always covered for children and youth under age 21
- Mobile crisis services can provide relief to youth experiencing a behavioral health crisis; reduce the risk or danger and subsequent harm; and avoid unnecessary emergency department care, psychiatric inpatient hospitalizations, and law enforcement involvement
- In January 2023, counties began implementing the qualifying mobile crisis services benefit in the SMHS and DMC or DMC-ODS delivery systems
  - Counties will develop a standardized screening tool to determine when mobile crisis teams should be dispatched and other policies and procedures to ensure mobile crisis services are delivered effectively to children and youth
  - The qualifying mobile crisis services benefit will be available statewide in SMHS and DMC or DMC-ODS delivery systems by December 31, 2023



Psychiatric Collaborative Care Management Services

- **Overview.** Providers can bill for **psychiatric collaborative care management services** when they reach out to a psychiatric or addiction medicine consultant to help treat a child's mental health and/or SUD
- **Consent.** The child and their parent or caregiver must give permission to consult with relevant specialist; consent can be verbal and must be documented in medical record
  - Starting at age 12 and older, a child may, without parental consent, receive services related to drug and alcohol abuse treatment/counseling and mental health outpatient care
- **Billing Codes & Services.** Reimbursable CPT codes include 99492 (70 minutes in first month), 99493 (60 minutes in subsequent month), and 99494 (additional 30 minutes) for the following services in collaboration with a consulting provider:
  - Outreach and engagement in treatment with another qualified health care professional
  - Initial assessment of the child with a validated rating scale and development of a treatment plan
  - Review and modifications of the plan with the consulting provider
  - Tracking patient follow-up and entering info in a registry
  - Participating in weekly caseload consultation with consulting provider
  - Providing brief interventions

99492 and 99493 can be billed once per month, but not in the same month. 99494 can be billed twice per month

For additional information, see the Evaluation & Management Provider Manual re: Psychiatric Collaborative Care Management Services

County SMHS: Intensive Home-Based Services (IHBS) Example



- A ten-year-old child enrolled in Medi-Cal managed care has been experiencing issues with self-regulation and behavioral outbursts in school
- The child's pediatrician screens the child using the standardized screening tool and determines the child would benefit from SMHS
- The child's pediatrician refers the child to the county mental health plan

- A pediatric psychologist paneled at the county mental health plan conducts an additional assessment and determines that IHBS supports (e.g., interventions designed to correct or ameliorate conditions that interfere with functioning, and improve the family's ability to help the child successfully function at home/school/community) would be appropriate to effectively serve the child's intensive behavioral needs and engage the child's caregivers to support building functional skills

- The psychologist submits the IHBS mental health documentation requirements prescribed by the county mental health plan, consistent with the mental health plan's process for authorizing IHBS

- The county mental health plan agrees with the psychologist in determining that the IHBS services are medically necessary based on the child's strengths and needs

- The county mental health plan delivers IHBS to the child in their home and community setting

California Children's Services (CCS) Requirements for Primary Care Providers (1 of 2)

CCS is an important component of the Medi-Cal system of care available to qualifying children and youth under age 21 with certain diseases or health problems.

- The CCS Program, which is administered as a partnership between county health departments and DHCS, provides diagnostic and treatment services, medical case management, and physical and occupational therapy services
- Care for children enrolled in CCS is provided by CCS-paneled providers, CCS-approved special care centers (SCCs), and approved pediatric acute care hospitals
- The CCS Medical Therapy Program (MTP) provides direct physical and occupational therapy services for a subset of CCS-eligible children with physical disabilities
- Note: A child can be eligible for CCS services regardless of whether they are eligible for Medi-Cal or enrolled in a Medi-Cal managed care plan



Examples of CCS-eligible conditions include, but are not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, lead poisoning, and traumatic injuries.

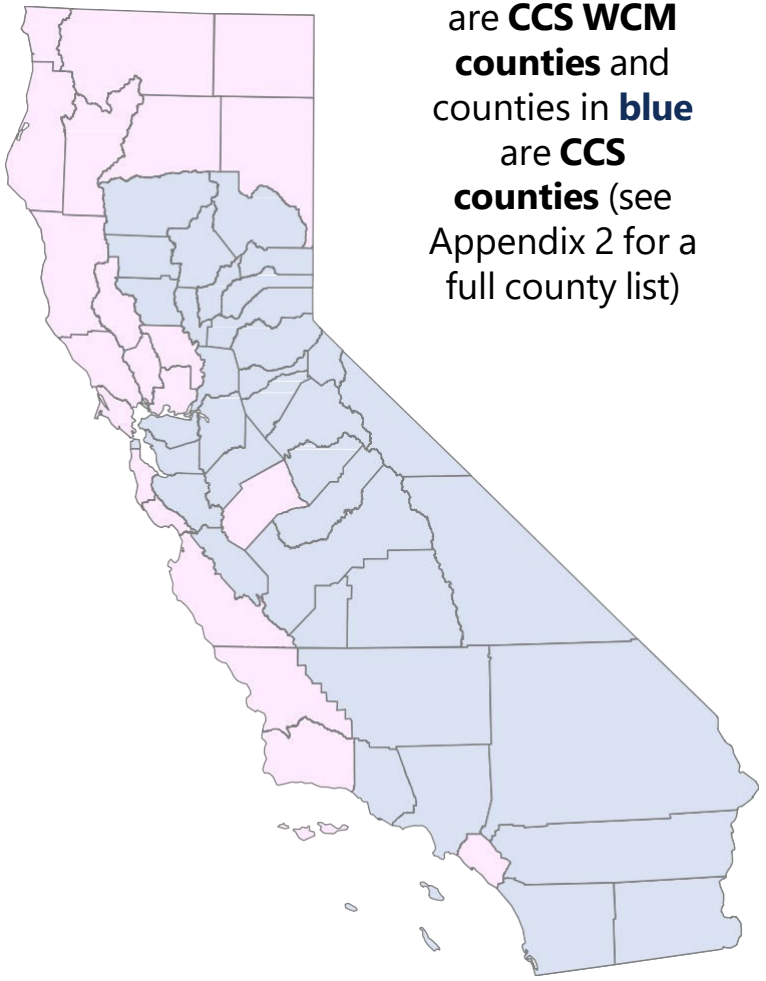
California Children's Services (CCS) Requirements for Primary Care Providers (2 of 2)

Anyone can make a referral to the CCS Program, if they suspect that a child is eligible for CCS. Primary care providers or specialists must provide a baseline health assessment and diagnostic evaluation ~~w~~with sufficient clinical to establish – or raise a reasonable suspicion – that a child has a CCS-eligible medical condition.

- Children with CCS-eligible conditions must be referred to the local CCS Program on the same day after the condition is identified
- Referrals can be made via phone, secure email, mail, or fax, and include supporting medical documentation sufficient to allow for a medical eligibility determination
- Access here for the list of phone and fax numbers for each local CCS Program

Providers must continue to provide all covered services until the CCS Program eligibility is determined, and the managed care plan must reimburse the provider for those services.

Classic CCS Counties & CCS WCM Counties



Counties in **pink** are **CCS WCM counties** and counties in **blue** are **CCS counties** (see Appendix 2 for a full county list)

- California's 58 counties provide CCS through two different models:
  - In Classic CSS counties, the treatment for the CCS qualifying condition, including medical case management, is provided directly through the CCS county office
  - In CCS Whole Child Model (WCM) counties, the treatment for the CCS qualifying condition, including medical case management, is "carved in" to the managed care plan's responsibility
- The eligibility criteria for CCS are the same in both Classic CCS and CCS WCM counties
- If the local CCS Program or DHCS finds that the child's condition is not medically eligible, then the managed care plan in both Classic CCS and CCS WCM counties remains responsible for providing and reimbursing for the cost of services if determined to be medically necessary
- Local CCS county offices or DHCS determine if a child is eligible for CCS in both Classic CCS and CCS WCM counties
  - Counties with populations greater than 200,000 – known as **independent counties** – have county staff perform medical eligibility determinations
  - Counties with populations less than 200,00 may choose to be independent counties or **dependent counties;** DHCS is responsible for determining medical eligibility for dependent counties

Medi-Cal for Kids & Teens Skilled Nursing Services (1 of 2)

Skilled nursing services are critical for children and youth with serious physical health conditions, many of whom often qualify for CCS.

- Children and youth under age 21 may be eligible for Medi-Cal for Kids & Teens Skilled Nursing Services, including:
  - **Private Duty Nursing (PDN)** is skilled nursing services provided by a licensed nurse (RN or LVN) on a shift basis at a child's home for children who require more individualized and continuous care than what would be provided by a visiting nurse; otherwise known as 'shift' nursing
  - **Pediatric Day Health Care (PDHC)** is skilled nursing services provided as day programs at PDHC facilities of less than 24 hours, including (but not limited to) comprehensive case management; nutrition and nursing services; developmental and educational services; and physical, occupational, speech therapy



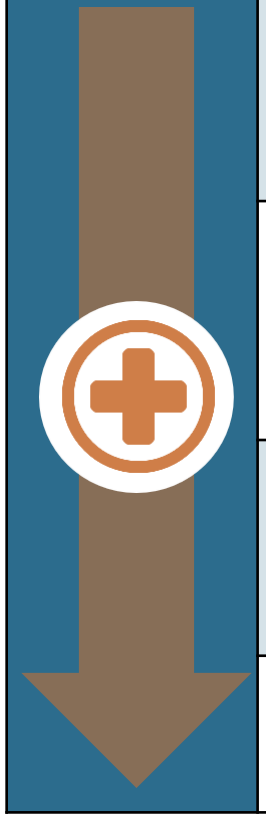
*Limits based on a monetary cap or budgetary constraint may **not** be imposed; for example, if a provider determines it is medically necessary for a child to have 20 hours per week of private duty nursing, then the managed care plan cannot limit the service to 10 hours per week*

Medi-Cal for Kids & Teens
Skilled Nursing Services (2 of 2)

Providers must refer a child for skilled nursing services if they determine the services are medically necessary for the child. Service authorization for PDN and PDHC include:

CCS–Eligible Members	CCS WCM–Eligible Members	Non-CCS-Eligible Members
» Providers must fax or secure email a service authorization request (SAR) to the child's local CCS County office or upload the SAR into the Provider Electronic Data Interchange (PEDI) for the local CCS county office or DHCS to adjudicate the PDN or PDHC service request » Providers must submit with the SAR a Plan of Treatment (POT) signed by a CCS paneled physician and supporting clinical documentation such as medical records and discharge summary notes	» Providers must submit a prior authorization request to the managed care plan to approve or deny the PDN or PDHC service request » Providers must submit with the prior authorization request a POT, supporting clinical documentation, and other information, as specified by the managed care plan for review and authorization	» Providers must submit prior authorization requests to the managed care plan to approve or deny the PDN or PDHC service request » Providers must submit with the prior authorization request a POT, supporting clinical documentation, and other information, as specified by the managed care plan for review and authorization

Medical Necessity Review Criteria: Private Duty Nursing Example



» An infant with chronic lung disease has a tracheostomy and ventilator and requires PDN services » The infant is enrolled in the CCS Program and enrolled in a managed care plan in a Classic CCS County
» The CCS-paneled provider submits a SAR requesting RN-level PDN services to be performed in the child's home; attachments include the POT signed by the CCS paneled physician and supporting clinical documentation
» The CCS Program adjudicator determines that the services requested relate to the CCS-eligible condition and they conduct a medical-necessity review and determine that the services are within the scope of an LVN
» The CCS Program adjudicator modifies the SAR to reflect the appropriate provider type to render the PDN services and approves the PDN services and units

Test Your Learning

- Do children without diagnosed mental health conditions qualify for mental health services provided by managed care plans and/or mental health plans?
- Can a child receive services from a managed care plan, county mental health plan, and Drug Medi-Cal (DMC)/Drug-Medical Organized Delivery System (DMC-ODS) county at the same time?
- If you believe a child would benefit from family therapy or other supports, are those services available under Medi-Cal for Kids & Teens?
- How does a child enrolled in Medi-Cal managed care and *not* eligible for CCS receive skilled nursing services?

Appendix



DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Billing Codes

Service Category	Billing Codes
Blood lead screening	CPT 36415, 36416, 83655, 99401, 99402, 99403, 99404
Developmental screening	CPT 96110
ASD screening	CPT 96110 and modifier KX
Depression screening	HCPCS G8431 and G8510
Postpartum depression screening	HCPCS G8431 and G8510
Vision screening	CPT 99173*, 99381-99385 and 99391-99395 **For school-based enrolled Medi-Cal providers only*
Hearing screening	CPT 92551 and 92552; ICD-10-CM diagnosis codes Z00.121, Z00.129, Z01.10, or Z01.11
Oral health screening	CPT 99188, 99381 – 99383, 99391 – 99393; HCPCS D1206
ACEs/trauma screening	HCPCS G9919, G9920
Dyadic services	HCPCS H1011, H2015, H2027, T1027
As needed screenings	As needed screenings should be billed using the appropriate preventive medicine CPT code and ICD-10 CM diagnosis code Z00.8 (encounter for other general examination)

Classic CCS Counties & CCS WCM Counties (2 of 2)



KEY

- CCS WCM counties
- CCS counties

Sources

For the list of sources related to this training, please refer to the "MCKT Provider Training Sources" located on the MCKT Website, Provider Information page.

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES