CALIFORNIA VICTIM COMPENSATION BOARD

TEXT OF REGULATIONS

PROPOSED AMENDMENTS TO CALIFORNIA CODE OF REGULATIONS
TITLE 2. ADMINISTRATION
DIVISION 2. FINANCIAL OPERATIONS
CHAPTER 1. CALIFORNIA VICTIM COMPENSATION BOARD
ARTICLE 5.6. INDEMNIFICATION OF VICTIMS OF CRIME
SECTIONS 649.26, 649.29.1, and 649.29.2

As Submitted by California Victim Compensation Board on January 15, 2026

Proposed Text: ***Page No.:***

§ 649.26 Direct Payments to Providers

(a) ~~If the VCP~~ When the Board authorizes direct payment to a healthcare ~~provider of VCP services~~ or mental health provider of CalVCB services, the ~~VCP~~ Board may require the provider to submit bills using CMS 1450, CMS 1500 or American Dental Association bill forms for verification of services provided. ~~Applicants~~ Claimants are not required to use the above-noted forms to request reimbursement of eligible pecuniary losses that they paid.

(1) Mental health providers must submit the information as detailed in §649.29.1 (b)(1)-(9) either in advance of or along with their first bill or CMS 1500. Sessions may be reimbursed once the required information has been provided to and approved by the Board.

(2) All bills must be submitted to any and all available insurance, benefit programs, or other reimbursement sources prior to being submitted to the Board as CalVCB is the payor of last resort. If an expense is not otherwise covered, or is only partially covered, providers must submit a copy of the explanation of benefits or other verification from the insurer, benefit program, or other reimbursement source, documenting the denial or partial payment along with the CMS 1500. No payment will be made until all other potential reimbursement sources are exhausted and the necessary information regarding efforts to seek reimbursement from other sources is received.

(b) The ~~VCP~~ Board shall inform the ~~victim or derivative victim~~ claimant of ~~his or her~~ their right to object to direct payments by ~~VCP~~ CalVCB to providers of services in accordance with Government Code section 13957.7(c)(1). In the event that the ~~victim or derivative victim~~ claimant asserts such right the ~~VCP~~ Board may reimburse pecuniary loss to the ~~victim or derivative victim~~ claimant only in amounts equal to sums actually paid out by the ~~victim or derivative victim~~ claimant to the service provider and only upon submission by the ~~victim or derivative victim~~ claimant of evidence of such payments, subject to the rates and limitations set by the Board in accordance with applicable law. Following such an objection, direct payment shall be made to the provider only upon a demonstration of good cause as determined by the board.

(c) For consideration of payment for mental health counseling over the claimant's authorized session limit, ~~mental health providers must submit the VCP Treatment Plan and the VCP Additional Treatment Plan for review and approval within 90 days of the date VCP receives the bill for sessions that exhaust the claimant's authorized session limit~~ providers must submit the information outlined in §649.29.1 (e)(1)-(11) to the Board for approval before additional sessions may be considered for payment. ~~If the VCP Treatment Plan and VCP Additional~~

~~Treatment Plan are not submitted within the 90-day timeframe, bills for all dates of service that exceed the authorized session limit will be returned and will not be considered for payment. However, bills for dates of service provided after the VCP Treatment Plan and VCP Additional Treatment Plan are received may be considered if the VCP Additional Treatment Plan is approved and the authorized session limit is increased.~~

(1) Providers must submit the information to the Board for review and approval within 90 days of the date the Board receives the bill for sessions that exhaust the claimant's authorized session limit. If the required information is not submitted within the 90-day timeframe, bills for all dates of service that exceed the authorized session limit will be returned and will not be considered for payment. However, bills for dates of service provided after the required information is received may be considered if the additional treatment is approved and the authorized session limit is increased.

(d) Outpatient mental health services that exceed statutory maximums or for inpatient psychiatric, psychological, or other mental health counseling providers must submit the information outlined in §649.29.2 (a)(1)-(12) to the Board for approval before treatment may be considered for payment

(1) Providers must submit the information to the Board for review and approval within 90 days of the date the Board receives the bill for outpatient mental health services that exceed statutory maximums or for inpatient mental health treatment. If the required information is not submitted within the 90-day timeframe, bills for all dates of service that exceed statutory maximums or for inpatient mental health treatment will be returned and will not be considered for payment. However, bills for dates of service provided after the required information is received may be considered if the dire or exceptional treatment is approved.

Note: Authority cited: Section 13974, Government Code.
Reference: Section 13957.7 Government Code.

§ 649.29.1. Mental Health Benefits

(a) The Board may reimburse a claimant for the expense of outpatient mental health services incurred as the direct result of a qualifying crime in an amount not to exceed the statutory benefit limits set forth in Government Code §13957(a)(2)(A) and (B) and consistent with Government Code §13959(d).Outpatient mental health services that may be reimbursed include, but are not limited to, the following:

(1) In person or telehealth individual or family mental health therapy sessions;

(2) Group therapy;

(3) A maximum of five (5) hours of case management per claimant, which will not be counted as part of their mental health session limit;

(4) Medication management;

(5) Biofeedback therapy, when provided by a mental health provider authorized by the Board of Behavioral Sciences ;

(6) Hypnotherapy, when provided by a mental health provider authorized by the Board of Behavioral Sciences;

(7) Music therapy, when provided by a mental health provider authorized by the Board of Behavioral Sciences;

(8) Psychological and Neuropsychological testing;

(9) Interpreter services received during mental health treatment; and

(10) Transportation expenses to and from mental health appointments.

(b) Claimants and/or providers must submit the information listed below to the Board with their initial request for reimbursement of mental health services. Sessions may be reimbursed once the required information has been provided to and approved by the Board. The required information includes:

(1) The claimant's name and CalVCB application number;

(2) A brief description of the qualifying crime, including the date it occurred and any relevant details such as the suspect's name and relationship to the victim;

(3) The date treatment began and the date treatment terminated, if applicable;

(4) A statement that the treatment is or is not necessary as a direct result of the qualifying crime;

(5) The treating provider's or therapist's name, license number, contact information, and provider agency or organization name;

(6) The supervising provider's name, license number, contact information, and provider agency or organization name, if applicable;

(7) If an EOB or denial is unable to be provided, a statement indicating the reason why including, but not limited to: the network provider is located more than 45 miles from the claimant's residence; the network provider is not able to provide treatment within 45 days of request due to scheduling issues; or the network provider has a limited number of Medi-Cal slots and all Medi-Cal slots have been filled;

(8) A declaration of certification regarding the information in subsections (1) through (7) above, signed under penalty of perjury by the treating provider or therapist;

(9) A declaration of certification regarding the information in subsections (1) through (7) above, signed under penalty of perjury by the supervising provider or therapist, if applicable;

(10) A declaration of certification regarding the information in subsections (1) through (7) above, signed under penalty of perjury by the claimant.

(c) Providers must complete a treatment plan at the beginning of treatment that includes the information listed below to document the treatment is necessary as a direct result of a qualifying crime. Treatment plans must include:

(1) The claimant's name and CalVCB application number;

(2) A brief description of the qualifying crime, including the date it occurred and any relevant details such as the suspect's name and relationship to the victim;

(3) A statement estimating the percentage of treatment needed as a direct result of the qualifying crime;

(4) If there was a delay in treatment of three years or longer, a description of the events, behaviors, or reasons the claimant waited to seek treatment;

(5) If there was a break in treatment over one year, a description of the events, behaviors, or reasons the claimant paused treatment;

(6) If the claimant was below age four when treatment began, explain what behaviors or symptomologies are being treated and how they are a result of the qualifying crime;

(7) For post-crime primary caretakers, a statement as to whether the treatment is necessary for treatment of the minor direct victim;

(8) The date treatment began, the most recent date of treatment, the date that treatment completed (if applicable), and the number of session hours provided and types of sessions provided;

(9) The treating therapist's name, license number, contact information, and provider agency or organization name, if applicable;

(10) The supervising therapist's name, license number, contact information, and provider agency or organization name, if applicable; and

(11) A declaration of certification regarding the information in subsections (1) through (10) above, signed under penalty of perjury by the treating provider or therapist; and

(12) A declaration of certification regarding the information in subsections (1) through (10) above, signed under penalty of perjury by the supervising provider or therapist, if applicable.

(d) Treatment plans must be kept in the claimant's file, except for the following circumstances when it must be submitted to the Board with the first request for reimbursement:

(1) Upon the Board's request; or

(2) If treatment is less than 100 percent a direct result of the qualifying crime; or

(3) There was a delay in treatment of three years; or

(4) There was a break in treatment over one year; or

(5) If the claimant was below age four when treatment began; or

(6) If the treatment is for a post-crime primary caretaker.

(e) Requests for additional mental health treatment sessions beyond the approved session limit must be submitted to the Board when the claimant is eight (8) sessions away from reaching their authorized session limit. The request must include the information listed below and be approved by the Board before additional sessions may be considered for payment. Requests for additional treatment must include:

(1) The claimant's name and CalVCB application number;

(2) A brief description of the crime for which mental health sessions are being provided, including the date the crime occurred and any relevant details provided by the claimant;

(3) The date treatment began, the most recent date of treatment, and the date treatment terminated, if applicable;

(4) The number of session hours provided for individual, group, and family/conjoint therapy, if applicable;

(5) The treating therapist's name, license number, contact information, and providing agency or organization name, if applicable;

(6) The supervising therapist's name, license number, contact information, and providing agency or organization name, if applicable;

(7) An explanation why treatment could not be completed within the authorized session limits and why additional sessions are required to complete treatment;

(8) A percentage estimate as to how far along the claimant is towards meeting and completing treatment goals and an estimate as to how many additional sessions are needed to complete treatment;

(9) A statement that the claimant has or has not made progress since treatment began or since the last request for additional treatment was made. If no progress has been made, a statement explaining why and how additional treatment will overcome any hindering factors of progress and what those factors are;

(10) A description of the type of specialized or inpatient services requested (e.g. Inpatient Psychiatric Hospitalization Day Treatment/Partial Hospitalization, Residential Treatment Center, Intensive Outpatient Program, etc.), if applicable;

(11) A description of the dire or exceptional circumstances that require more extensive treatment and an explanation as to why treatment could not be completed thus far and why additional sessions are required to complete treatment, if applicable;

(12) A declaration of certification regarding the information in subsections (1) through (9) above, signed under penalty of perjury by the treating provider or therapist; and

(13) A declaration of certification regarding the information in subsections (1) through (11) above, signed under penalty of perjury by the supervising provider or therapist, if applicable.

(f) A new treatment plan and request for additional treatment sessions, if applicable, must be submitted to the Board before reimbursement for treatment will be made when:

(1) The claimant's treating therapist, who requires licensed supervision, changes provider agencies or organizations;

(2) The claimant's treating therapist and provider agency or organization changes; or

(3) The claimant pauses treatment for one year or longer and then resumes treatment with the same provider.

(g) If a claimant changes therapists within the same provider agency or organization, a new treatment plan is not required. In this case, the succeeding therapist is not

considered a new provider and must continue to assess the claimant's progress since treatment began with the provider agency or organization.

Note: Authority cited: Sections 13957 and 13959 Government Code.
Reference: Sections 13920, 13957, 13957.2, and 13957.7, Government Code.

§ 649.29.2 Dire or Exceptional Circumstances and Specialized Mental Health Services

(a) The Board may reimburse a claimant for outpatient mental health services that exceed statutory maximums or for inpatient psychiatric, psychological, or other mental health counseling if it is determined that dire or exceptional circumstances require additional treatment. When requesting treatment in excess of statutory maximums, the claimant's mental health provider must provide the Board with the information listed as detailed in §649.29.1 (e)(1)-(13) before treatment may be approved.

Reference: Section 13957.7 Government Code.