MADERA COUNTY BEHAVIORAL HEALTH SERVICES MANAGED CARE MANUAL

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MANAGED CARE MANUAL

Contents

INTRODUCTION

Madera County Behavioral Health Services (BHS) is responsible for the management of medically necessary Specialty Mental Health Services. This network includes County operated programs, and contractor provider known as organizational providers, facility providers, and private practitioner such as psychiatrists, psychologist, licensed clinical social workers, licensed marriage and family therapist, and mix group providers known as network provider. This manual provides standardized procedures for all providers.

BACKGROUND

- In 1966, a Public County run Medi-Cal System called Short-Doyle/Medi-Cal (SD/MC) was implemented.
- In 1972, a private provider system called Fee-for-Service (FFS/MC) became effective.
- AB 757 (1994) authorized the transfer of state funding for FFS/MC specialty mental health services from the Department of Health Services (DHS) to the Department of Mental Health (DMH).
- Effective January 1, 1995, the responsibility and funding for psychiatric inpatient hospital services were transferred to the local county.
- April 1, 1998, Mental Health Plan (MHP) became responsible for authorization and funding of FFS/MC specialty mental health professional and nursing facility services.

VISION, MISSION, CORE

VISION STATEMENT

We envision a world where all person with addictions and mental illness can achieve recovery and can live with dignity and respect as valued members of their families and communities.

MISSION

To promote the prevention of and recovery from mental illness and substance abuse for the individuals, families, and communities we serve by providing accessible, caring and culturally competent services

CORE VALUES

We, the employees of Madera County Behavioral Health Services, value:
The promotion of wellness and recovery.
The integrity of individual and organizational actions.
The dignity, worth and diversity of all people.
The importance of human relationships.
The contribution of each employee.

DEFINITIONS

Authorization Unit

The Madera County Mental Health Plan is composed of clinical staff responsible for the review and authorization of requests for specialty mental health services from providers and beneficiaries.

Beneficiary

A Madera County Medi-Cal recipient. It is the responsibility of the provider to monthly verify the client Medi-Cal eligibility.

Consumer/Client/Patient

An individual who is currently requesting or receiving mental health services from Madera County Mental Health and/or has received services in the past.

Consumer Access Line

A Statewide toll-free telephone line can be reached by dialing (888) 275-9779. Additional access lines are available by calling (559) 673-3508 or TTY (800) 735-2929. All lines offer linguistic capability for consumers/beneficiaries 24 hours, 7 DAYS A WEEK as well as information on how to access specialty mental health services, including services needed to treat a consumer's urgent condition, and how to use the consumer problem resolution and fair hearing process.

Contract Provider

A licensed mental health practitioner who enters into an agreement with Madera County Mental Health Plan to provide specialty mental health services to Madera County Medi-Cal beneficiaries.

Culture Competence

Provider will provide care to client with diverse values, beliefs, and behaviors, including delivery to meet clients' social, cultural, and linguistic needs. Providers must obtain the required hours of on-going continuing education credits to maintain their licensure.

Early & Periodic Screening, Diagnosis & Treatment (EPSDT)

EPSDT is a Medi-Cal entitlement that provides comprehensive health care services for beneficiaries under 21 years of age.

Fee for Service Mental Health Provider

Private hospitals and practitioners who provide mental health services to Medi-Cal recipients and bill the intermediary.

Grievance

Grievance is a statement registered by a provider or client regarding a problem with any aspect of service. Grievances can be presented by completing a Grievance Form and submitting it to the MHP.

Group Provider

Group Provider means an organization that provides specialty mental health services through two or more individual providers. Group providers include entities such as independent practice associations, hospital outpatient departments, health care service plans and clinics.
Authority: Section 14680, Welfare and Institutions Code Reference: Sections 5777 and 14684, Welfare and Institutions Code

Madera County Medi-Cal Beneficiaries

Individuals who are Medi-Cal eligible and carry Madera County Code (20) on their Medi-Cal Identification Card.

Madera County Mental Health Plan (MHP)

The county organization responsible for the Specialty Mental Health needs of all Medi- Cal-eligible residents of Madera County.

Medical Necessity

The principal criterion by which Madera County MHP determines authorization and/or reauthorization for covered specialty mental health services for Madera County Medi-Cal beneficiaries. Reference MHP 36.00 Medical Necessity Criteria.

Mental Health Services

Mental Health Services (MHS) are individual or group therapies and interventions that are designed to provide reduction of mental disability and restoration, improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Service activities may include, but are not limited to assessment, plan development, therapy, rehabilitation and collateral.

MHS are provided to Medi-Cal beneficiaries that meet medical necessity criteria for Specialty Mental Health Services (SMHS), and based on the beneficiary's need for MHS established by an assessment and documented in the client plan.

Network Provider

Individual Provider means licensed mental health professionals whose scope of practice permits the practice of psychotherapy without supervision who provide specialty mental health services directly to beneficiaries.
Individual provider includes licensed physicians, licensed psychologists, licensed clinical social workers, licensed marriage, family therapists and registered nurses certified in psychiatric nursing by the Board of Registered Nursing. Individual provider does not include licensed mental health professionals when they are acting as employees of any organizational provider or contractors of organizational providers other than the MHP.
Authority: Section 14680, Welfare and Institutions Code Reference: Sections 5777 and 14684, Welfare and Institutions Code

Non-Contracting Provider

Non-Contracting Provider is a mental health provider who does not have a contract with the MHP, but may do business with the MHP for specific reasons, e.g., provision of emergency, out-of-area or one-time client care.

Non Discrimination

See Contract Discrimination Prohibited for details related to hours of operation, or on the basis of race/ethnicity, color, national origin, sexual orientation, sex, disability, veteran status, or age.

Organizational Provider (Org Provider)

Organizational provider means a provider of specialty mental health services other than psychiatric inpatient hospital services or psychiatric nursing facility services that provides the services to beneficiaries through employed or contracting licensed mental health or waivered/registered professionals and other staff. The MHP is an organizational provider when specialty mental health services are provided to beneficiaries by employees of the MHP.

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

Primary Care Physician (PCP)

A physician responsible for supervising, coordinating, and providing initial and primary care to beneficiaries. Other responsibilities include initiating referrals for specialist care and maintaining the continuity of beneficiary's care.

Public Managed Care or Mental Health Plan (MHP)

The Madera County Mental Health Plan (MHP) is a system which is responsible for providing clinical services and managing fiscal risk of its members and serves public sector clients with public funds and with public accountability.

Quality Management Clinician/Coordinator

An employee of Madera Behavioral Health Services, whose responsibilities include, but are not limited to, ensuring that procedures are in place to inform consumers about how to initiate the grievance process, reviewing grievances, reporting grievances to the QIC, monitoring actions to resolve grievances, and monitoring the quality of services through surveys, studies and reviews.

Services

Include inpatient or outpatient Medi-Cal mental health services.

Specialty Mental Health Services

Those mental health services provided by county departments of mental health and their contract providers under the Rehabilitation model as distinguished from mental health services provided by primary care and/or fee-for-service mental health providers.

Short-Term Residential Therapeutic Program (STRTP)

A residential facility that provides integrated program of specialized and intensive care and supervision, services and supports, treatment, and short-term 24-hour care and supervision to children.

Urgent Condition

A clinical situation experienced by a beneficiary that, without timely intervention, is likely to result in an emergency psychiatric condition within three days.

PROVIDER NETWORK

The Mental Health Department offers medically necessary specialty mental health services to beneficiaries through its own clinics and through a provider network. The provider network services are programs, wraparound services (SB163) and licensed network providers.

Licensed Network Providers

The network consists of Licensed Psychologists, Licensed Psychiatrists, Licensed Marriage and Family Therapists, and Licensed Clinical Social Workers. Authorized specialty mental health services must be provided in coordination with any acute services, other county mental health services, and physical health care services which the beneficiary may require

Wraparound (SB163) Organizational Providers

Is an organizational provider that provides family-focused, strength-based, and individualized services to help children at imminent risk of placement to remain in their home. The staff ensures that care is available 24/7 to keep the youth and families stable and safe. Wraparound is an integrated, multi-agency, community- based process grounded in a philosophy of unconditional commitment to support families to safely and competently care for their children. The single most important outcome of the Wraparound approach is a child thriving in a permanent home and maintained by normal community services and supports.

Tier 1 Target Population

Children eligible for Tier 1 Wraparound services must either be: Adjudicated as a dependent (WIC 300) of the Dependency Court or Adjudicated as a Ward (WIC 601 or 602) of the Juvenile Court or AB3632.

Child /Youth currently placed in a RCL 10 or above group home and within 60 days of transitioning. Child/Youth is currently at imminent risk within 30 days of replacement into a RCL 10 or above group home.

Tier 2 Target Population

Children eligible for Tier 2 Wraparound services must: Have an open Department of Children and Family Services (DCFS) case (Court or Voluntary) Qualify for Early and Periodic Screening Diagnostic and

Treatment Program (EPSDT), have an urgent and/or intensive mental health need which causes impairment at school, home and/or in the community.

TBS Organizational Providers

Therapeutic Behavioral Services (TBS) are supplemental specialty mental health services covered under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit. Title 9, California Code of Regulations (CCR), Section 1810.215 states, "EPSDT supplemental specialty mental health services" means those services defined in Title 22, [CCR] Section 51184, that are "provided to correct or ameliorate the diagnoses listed in Section 1830.205, and that are not otherwise covered by this chapter."

TBS is an intensive, individualized, one-to-one behavioral mental health service available to full-scope Medi-Cal children/youth (and their families) who are under 21 years old and are dealing with serious emotional challenges. TBS is never a primary therapeutic intervention; it is always used in conjunction with a primary specialty mental health service. TBS is available for children/youth who are being considered for placement in an RCL 12 or above (whether or not an RCL 12 or above placement is available) or who meet the requirements of at risk of hospitalization in an acute care psychiatric facility (whether or not the psychiatric facility is available). TBS is designed to help children/youth and their parents/caregivers (when available) manage these behaviors utilizing short-term, measurable goals based on the child' and family's needs. Eligibility for TBS Services is based on Medical Necessity and Class Certification. Each of the required criteria must be supported and substantiated by documentation.

Crisis Services Organizational Providers

A service lasting less than 24 hours to or on behalf of a client for a condition that requires a more timely response than a regularly scheduled visit and is delivered at a site other than a Crisis Stabilization program. Service activities include but are not limited to Assessment, Collateral, and Therapy.

Intensive Home Based Services Providers

Intensive Home Based Services (IHBS) are individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child/youth's functioning. Services aim at helping the child/youth build skills necessary for successful functioning in the home and community and improving the child/youth's family's ability to help the child/youth successfully develop and maintain those skills. IHBS services are provided

within the Child and Family Team (CFT) and in accordance with the Core Practice Model (CPM). The Child and Family Team (CFT) participates in the development of the child's and family's overall service plan which may include IHBS. Service activities may include, but are not limited to assessment, plan development, therapy, rehabilitation and collateral.

IHBS is provided to members of the Katie A. subclass as determined medically necessary.

TARGET POPULATION

The MHP serves as a gate-keeping function to provide screening and referral for all individuals who request public - funded mental health services. The MHP determines which individuals need specialty mental health services, which services are required, who will provide services, and how long services will be provided.

Madera County Medi-Cal beneficiaries who request specialty mental health services, meet the Medical Necessity Criteria (Attachment A1, Attachment 1, Attachment 2), and do not require intensive long term care may be referred to a network provider. Medi-Cal beneficiaries who are certified as eligible to receive specialty mental health services through Madera County MHP may be seen by a provider in individual, family, and group therapy.

Selection of a mental health plan provider may include consideration of the following:

- Service location which best meets the needs of the individual.
- Special needs of the individual including ethnicity, language, and culture.
- Clinician's expertise and resources required to treat the individual's condition.
- Individual's preference for provider.

In addition to the above criteria a wraparound (SB163) referral and recommendation must be reviewed and approved by Madera's Interagency Placement Committee (IPC).

TREATMENT AUTHORIZATION/OUTPATIENT SERVICES

Screening and Initial Authorization (Attachment D1)

Requests for outpatient mental health services may originate with a community agency, a primary care physician, a specialty mental health provider or with the beneficiary/family/legal guardian. All requests for services

excluding crisis after hours services and wraparound services begin with the scheduling of a mental health assessment. Appointments can be made by calling (559) 673-3508, 1(888) 275-9779 or TTY 1 (800) 735-2929.

All requests for wraparound services must be reviewed and approved by the Interagency Placement Committee before the Mental Health Plan can authorize specialty mental health services.

If the beneficiary is determined to be eligible for mental health services, s/he has the right to request a specific county contracted mental health provider. The beneficiary's choice, past history of treatment, and ability to meet special needs will be carefully considered in selecting a provider. However, the MHP reserves the right to determine the most appropriate mental health provider.

All planned services to beneficiaries **MUST BE PRE-AUTHORIZED** by the MHP. **Services provided to beneficiaries without authorization will not be reimbursed.** The authorization period ends when the allowed visits have been expended, when the authorization period ends or 30 days from the date of the assessment. All authorizations must be submitted to the MHP for approval 30 days prior to the requested authorization period begin date.

Beneficiary/Family/Legal Guardian who will receive services from a Network Provider, will be given a choice of two (2) providers, with their names, addresses, and phone numbers, unless they prefer to be given one name only.

The MHP clinician will contact the Network Provider whom the Medi-Cal beneficiary selects to verify s/he is accepting new Medi-Cal clients. The MHP will then send an authorization for one (1) assessment visit plus two (2) follow up session to the contracting provider over a period of 30 days. Providers will be required to schedule an initial visit with an authorized beneficiary within five (5) working days of the beneficiary's request for an appointment unless the beneficiary requests a later date.

If the beneficiary requires a comprehensive system of care which includes, but is not limited to, intensive case management, medication evaluation and management, and Therapeutic Behavioral Services (TBS), the MHP may choose to refer clients to a Madera County Behavioral Health Services Program for these services instead of a Network Provider.

Assessment Documentation Standards/Treatment Plan Authorization

Assessment

A comprehensive mental health assessment (Attachment D3 for Children, Attachment D4 for Adults) includes the following areas:

- Relevant physical health conditions reported by the client will be prominently identified and updated as appropriate.
- Presenting problems and relevant conditions affecting the client's physical health and mental health status will be documented. For example: living situation, daily activities, social support.
- Documentation will describe client strengths in achieving client plan goals.
- Risk Assessment--Special status situations that present a risk to client or others will be prominently documented and updated as appropriate.
- Documentation will include medications that have been prescribed by mental health plan physicians and primary care physicians (PCP), dosages of each medication, dates of initial prescriptions and refills, and documentation of informed consent for medications.
- Client self-report of allergies and adverse reactions to medications, or lack of known allergies/sensitivities will be clearly documented.
- A mental health history will be documented, including previous treatment dates, providers, therapeutic interventions and responses, sources of clinical data, relevant family information, and results of relevant lab tests and consultation reports.
- For children and adolescents, prenatal and perinatal events and complete developmental history is to be included.
- Past and present use of tobacco, alcohol, and caffeine, as well as illicit, prescribed and over-the-counter drugs must be documented.
- A relevant mental status examination is to be completed.
- A diagnosis from the most current Diagnostic and Statistical Manual of Mental Disorders (DSM) will be documented, consistent with the presenting problems, history, mental status evaluation and/or other assessment data.
- Client's signature verifying client's/guardian's participation in treatment planning and process.

After the assessment is completed and before the third session, if the treating clinician has determined that medical necessity has been met and continued specialty mental health services are indicated, the Network Provider will send a reauthorization form (Attachment D) to request additional mental health services to the MHP.

The MHP will review the assessment, treatment plan, and request for additional services to help insure that medical necessity is met and that appropriate treatment is being provided.
The MHP may authorize up to six months and a combination of mental health services including individual, family, TBS, IHBS, rehabilitation services, collateral, plan development, case management, Wraparound and group services.

The MHP may need additional information or documentation corrections to authorize the provider's request for services. The MHP will authorize some sessions to allow the provider time to provide the additional information or a plan of correction if documentation does not meet MHP Medi-Cal standards.

Treatment Plan (Attachment D)

All providers will complete a Treatment Plan based on the client's diagnosis, impairments, and functioning. The Treatment Plan will be consistent with the client's desired outcomes for treatment and will include:

- Treatment goals
- Treatment objectives
- Treatment modalities
- Treatment interventions
- Projected target dates for completion of treatment
- Cultural issues
- Client/Guardian strengths and commitment to participate in treatment
- Justification for extension of services

All services on the treatment plan must include the Child and Adolescent Needs and Strengths (CANS) outcome measures or the Adult Needs and Strength Assessment (ANSA).

All TBS assessments and provider plans must be completed before services can start.

Beneficiary's or parent/guardian's signature on the client plan/ reauthorization is required to provide documentation of the client's participation in and agreement with the plan. If the client refuses to sign or is unavailable for signature, the provider will include a written explanation of the refusal or unavailability; unless refused, client signature is required for full authorization. The provider will give a copy of the client plan to the client on request.

Reauthorization/Updated Annual Assessment Standards/ Treatment Plan (Attachment D6)

The Reauthorization/annual updated assessment will include:

- Symptoms
- Impairments
- Current psychotropic medication
- Current DSM diagnosis
- Progress toward previous treatment goals

The Treatment Plan will be consistent with the client's desired outcome for treatment and will include:

- Goals
- Objectives
- Treatment modalities
- Interventions
- Projected target dates for completion of treatment
- Cultural issues
- Client/Guardian strengths and commitment to participate in treatment
- Justification for extension of services
- Updated CANS every 6 (six) months

Beneficiary's or parent/guardian's signature on the client plan/ reauthorization is required to provide documentation of the client's participation in and agreement with the plan. If the client refuses to sign or is unavailable for signature, the provider will include a written explanation of the refusal or unavailability unless

refused, client signature is required for full authorization. Network Provider will give a copy of the client plan to the client on request.

Requests for reauthorization of services should be completed at least two weeks before authorization expires and submitted to MCBHS Managed Care Division. The provider will complete the Reauthorization Request form and Treatment Plan (Attachment D2, D3 or D4, D6) and return it to the MHP. The date of reauthorization will be the date received by the MHP.

If the MHP determines that the beneficiary continues to meet medical necessity, desires specialty mental health services and could benefit from the proposed treatment, additional sessions will be authorized up to a period of six months. A combination of individual, family and/or group therapy may be authorized.

Request for Psychological Testing

If the Network Provider believes psychological testing is indicated, the provider will contact the MHP to request authorization. The beneficiary's completed initial assessment and a written rationale for the request for psychological testing should be evaluated by the MHP to determine the appropriateness of the request.
If the request is authorized, a preset number of hours for administering, scoring, and report writing will be given by the MHP.
If the request is determined to be unnecessary the MHP will notify the provider of the decision and the reasons for denial. A Denial of authorization for requested services NOABD will be sent by the MHP to the beneficiary.

Authorization & Reimbursement Requests for Time Spent Doing Court Letters, Reports and Testimony

Upon notice from the legal system that a letter, report, or direct testimony is to be given regarding a client of a provider , the provider must contact the MHP to request authorization prior to completing such services. The provider will give a reasonable estimate as to how much time it will take to provide the needed information/testimony.

Once the MHP determines the reasonableness of the request, the appropriate number of requested hours will be authorized and reimbursed as per the established Madera County Behavioral Health Services (MCBHS) rate.

Once the provider has completed authorized services; s/he will use a Madera County Mental Health Plan "**Madera County Mental Health Billing Form**" to bill for the services (Attachment E). Invoices for authorized court services must be sent to the MHP per the contact payment of invoices terms.

Beneficiary Grievances & Appeals (Mental Health Plan Brochure [Attachment N5, N6])

When a beneficiary first receives non-emergency specialty mental health treatment services through the Madera County MHP, staff will provide the beneficiary (either in person or by mail) with a brochure, which describes the program, the process for obtaining services through the program, and the process for resolving grievances and appeals.

Emergency Services

Requests for emergency services should be referred to BHS Emergency Services at (559) 673-3508, (888) 275-9779 or TTY (800) 735-2929. This number may be accessed at any time.

Questions & Concerns (Attachment N1, N2)

Beneficiaries are encouraged to discuss concerns about mental health services with their provider or MHP staff. Beneficiaries may also talk to the Quality Management Coordinator at (559) 673-3508, (888) 275-9779; or TTY (800) 735-2929, call the Patients' Rights Advocate at (559) 673-3508; or call California Department of Mental Health Ombudsmen at (800) 896-4042, TTY (800) 735-2929. A consumer representative may also be contacted for assistance with forms by calling 673-3508, toll free (888) 275-9779 or TTY (800) 735-2929. (Attachment N1, N2)

Change of Provider

A beneficiary has the right to request a change of provider at any time in the duration of their treatment. Such request must be made by completing the Request for Change of Mental Health Provider form (Attachment) and submitting it in person, via mail to their Plan's MHP. MHP will make every effort possible to complete such requests on a timely and efficient manner.

Grievance Procedures (Attachment N3, N4)

If the beneficiary is unable to resolve a concern about any aspect of service other than an "adverse benefit determination", s/he may file a grievance at any time by completing a blue Grievance Form. Grievance Forms (Attachment N3, N4) and pre-addressed envelopes are to be available in the reception area of all Provider offices. Grievance Forms may be obtained from the Quality Management Coordinator by calling (559) 673-3508, toll free (888) 275-9779 or TTY (800) 735-2929.

A complaint is the same as a grievance. A complaint shall be considered a grievance unless it meets the definition of an "adverse benefit determination."

The Provider shall not discourage the filing of grievances. A beneficiary need not use the term "grievance" for a complaint to be captured as an expression of dissatisfaction and therefore, a grievance. Even if a beneficiary expressly declines to file a grievance, their complaint shall still be categorized as a grievance.

Notice of Adverse Benefit Determination

An Adverse Benefit Determination is defined to mean any of the following actions taken by the Provider:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
2. The reduction, suspension, or termination of a previously authorized service;
3. The denial, in whole or in part, of payment for a service;
4. The failure to provide services in a timely manner;
5. The failure to act within the required timeframes for standard resolution of grievances and appeals; or
6. The denial of a beneficiary's request to dispute financial liability.

The Provider must mail the notice to the beneficiary within the following timeframes:

1. For termination, suspension, or reduction of a previously authorized specialty mental health and/or DMC-ODS service, at least 10 days before the date of action, except as permitted under 42 CFR §§ 431.213 and 431.214;
2. For denial of payment, at the time of any action denying the provider's claim; or,
3. For decisions resulting in denial, delay, or modification of all or part of the requested specialty mental health and/or DMC-ODS services, within two business days of the decision.

The Plan must also communicate the decision to the affected provider within 24 hours of making the decision.

The following is a description of adverse benefit determinations and the corresponding NOABD templates:

1. **Denial of authorization for requested services**

   Use this template when the Plan denies a request for a service. Denials include determinations based on type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit. For DMC-ODS pilot counties, also use this template for denied residential service requests.

2. **Denial of payment for a service rendered by provider**

   Use this template when the Plan denies, in whole or in part, for any reason, a provider's request for payment for a service that has already been delivered to a beneficiary.

3. **Delivery system**

   Use this template when the Plan has determined that the beneficiary does not meet the criteria to be eligible for specialty mental health or substance use disorder services through the Plan. The beneficiary will be referred to the Managed Care Plan, or other appropriate system, for mental health, substance use disorder, or other services.

4. **Modification of requested services**

   Use this template when the Plan modifies or limits a provider's request for a service, including reductions in frequency and/or duration of services, and approval of alternative treatments and services.

5. **Termination of a previously authorized service**

   Use this template when the Plan terminates, reduces, or suspends a previously authorized service.

6. **Delay in processing authorization of services**

   Use this template when there is a delay in processing a provider's request for authorization of specialty mental health services or substance use disorder residential services. When the Plan extends the timeframe to make an authorization decision, it is a delay in processing a provider's request. This includes extensions granted at the request of the beneficiary or provider, and/or those granted when there is a need for additional information from the beneficiary or provider, when the extension is in the beneficiary's interest.

7. **Failure to provide timely access to services**

   Use this template when there is a delay in providing the beneficiary with timely services, as required by the timely access standards applicable to the delayed service.

8. **Dispute of financial liability**

   Use this template when the Plan denies a beneficiary's request to dispute financial liability, including cost-sharing and other beneficiary financial liabilities.

9. **Failure to timely resolve grievances and appeals**

   Use this template when the Plan does not meet required timeframes for the standard resolution of grievances and appeals.

Appeal Procedure

A beneficiary, or a provider and/or authorized representative, may request an appeal either orally or in writing. Appeals filed by the provider on behalf of the beneficiary require written consent from the beneficiary.

A beneficiary may appeal an "adverse benefit determination", " by the Mental Health Plan by calling the Quality Management Coordinator at (559) 673-3508 or toll free at (888) 275-9779, or TTY (800) 735-2929. An "adverse benefit determination", is when the MHP:

- Denies or limits authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
- Reduces, suspends, or terminates a previously authorized service;
- Denies, in whole or in part, payment for a service;
- Fails to provide services in a timely manner;
- Fails to act within the required timeframes for standard resolution of grievances and appeals; or
- Denies a beneficiary's request to dispute financial liability.

It is required for beneficiaries to file an appeal within 60 calendar days from the date on the NOABD. Plans shall adopt the 60 calendar day timeframe in accordance with the federal regulations. Beneficiaries must also exhaust the Plan's appeal process prior to requesting a State hearing.

State Fair Hearings

Beneficiaries must exhaust the Plan's appeal process prior to requesting a State hearing. A beneficiary has the right to request a State hearing only after receiving notice that the Plan is upholding an adverse benefit determination.

Beneficiaries must request a State hearing within 120 calendar days from the date of the Notice of Appeal Resolution (NAR), which informs the beneficiary that the Adverse Benefit Decision has been upheld by the Plan. Please see (attachment, either "your rights" or the client resolution brochure) for details regarding this process.

The Mental Health Plan Will:

- Provide a 24-hour toll-free telephone line for screening information. (888) 275-9779 or TTY (800) 735-2929. CALLERS WITH EMERGENCY SITUATIONS SHOULD CALL 911 EMERGENCY SERVICES.
- Return beneficiary non-emergency phone calls within four working hours of receipt.
- Provide telephone screening for all persons who request or are referred for specialty mental health services. The MHP calls the providers selected by the beneficiary and provides the name of the client and their phone number.
- Send the provider a notification packet (Attachment D1, D2, D3 or D4, D5) which identifies the client name, phone number and address.
    - It includes forms for the assessment, billing, discharge, and HIPAA privacy statement (Attachment B) to be signed by the beneficiary.
    - A copy of the signed HIPAA document is to be placed in the network provider's medical record for the beneficiary.
    - The original signed document is to be returned to the MHP with the first claim form.
- Maintain written and verbal communication with providers regarding status of authorizations.
    - Verbal confirmation of initial authorization will be telephoned to provider, within one working day, but not later than three (3) working days.
    - Written confirmation of initial authorization will be mailed or faxed to beneficiary and provider within seven (7) calendar days of receipt of request for service.
    - Reauthorizations will be mailed or faxed to the provider within seven (7) calendar days of receipt of request for reauthorization.

After three months or twenty-fourth (24) client visits, an MHP clinician will arrange to review the client's chart. The Quality Management Coordinator (QMC) will schedule quality chart reviews in the provider's office or the provider may mail the chart to the QMC ensuring the beneficiary's confidentiality. (See Attachment C) The MHP and QM staff will, whenever possible, coordinate their times for chart reviews to minimize inconveniencing the provider.

- If documentation does not support each billing, the MHP may withhold payment.

- Any documentation in the chart that does not meet MHP Medi- Cal standards will require a plan of correction by the provider in order for the chart to pass review.
- The MHP clinician will send a letter to request the plan of correction for any problems found in the review. Evidence of corrections made will be requested by MHP.

The MHP will provide the Network Provider with a supply of MHP brochures including Services Guide. (Attachment N5, N6) Providers are required to make these available to beneficiaries in their waiting areas.

The MHP clinician will track beneficiary appeals and grievances.

Every two (2) years a Provider Satisfaction Survey will be sent to all providers. Response will be analyzed in order to identify potential changes in service implementation. (Attachment I)

Site Visits Certification and Credentialing

Site visits are performed to ensure the safety of the physical environment, confidentiality of medical records, and the safe handling and distribution of medications in compliance with State standards. Site visits are performed by a MHP clinician no less than every two (2) years but may be done more often if indicated (Attachment K). As appropriate, the MHP will certify and/or credential the facility/staff for services to Madera County residents.

PROVIDER RESPONSIBILITIES

Providers Will:

- Offer an appointment for an assessment with an authorized beneficiary within five (5) working days of the beneficiary's request for services unless the beneficiary requests a later appointment.
- Inform all inquiring beneficiaries of the requirement for MHP authorization prior to beginning a course of treatment.
- Assist beneficiaries in obtaining from the MHP a list of community mental health resources. They include, but are not limited to:
    - List of credentialed mental health providers.
    - List of physical health care providers.
    - Adjunct services supportive to mental health, including:

        - Case Management
        - Therapeutic Behavioral Services
        - Medication evaluation and monitoring
        - Katie A services (ICC and IHBS) (note manual only reference IHBS svc)
        - Wraparound provider(s) (SB163)
        - Drug and Alcohol Services
        - Vocational Rehabilitation Services
        - Housing Authority
        - Social Services
        - Food Banks
        - Services for the Elderly (limited)
        - Parenting Classes
        - Anger Management Classes
        - Self-Help Support groups
        - Other services which may be obtained from the MHP office.
- Provider will give MHP a copy of the Treatment Staff Roster, if applicable, to include license number, National Provider Identifier (NPI) and/or evidence of credentialing upon request or within 30 days of credentialing or hiring of new staff.
- Provide the MHP with all requested information in order to expedite requests for reauthorization of services.
- Provide only those services to beneficiaries that are specified and authorized by the MHP.
- Assure that services are provided to beneficiaries who remain eligible for Medi-Cal reimbursement. (The MHP may assist in verification of eligibility at the beginning of each month.)
- Obtain beneficiary or parent/guardian signature on Reauthorization Requests to demonstrate beneficiary's participation in and agreement with Treatment Plan specified. (Attachment D)
- Maintain clinical records according to the following standards:
    - Each beneficiary will have a separate medical record.
    - All pages in the record will be filed chronologically.
    - Each page in the record will contain the beneficiary's name and ID number for identification.
    - Each record will be legible and written in black ink (or typed). White-out is not allowed in the medical record.

    - Make clinical records available to staff of the BHS and the State Department of Mental Health (DMH) upon request and send a plan of correction with evidence of the changes upon MHP request after the chart review.
- Report all unusual occurrences to the Behavioral Health Director/Designee at (559) 673-3508. (Attachment G)
    - An unusual occurrence is defined as any event that jeopardizes health and/or safety of consumers, staff, and/or members of the community, including, but not limited to physical injury and death. An example of an unusual occurrence includes, but is not limited to, epidemic outbreaks, poisonings, fires, major accidents, death from unnatural causes or other catastrophes.
- Notify the Behavioral Health Director/Designee at (559) 673-3508 of any suicide or homicide of a consumer that has been referred to them by the MHP for mental health services. (Attachment H)
- Assist beneficiaries who do not have a primary care physician to obtain one.
- Coordinate mental health services and physical health care with the primary care physician (PCP).

Progress Notes

Progress notes for mental health clients will be included in all client records for specialty mental health services. Client progress notes must include the following:

- Timely documentation of relevant aspects of client care.
- Client encounters, including relevant clinical decisions and interventions.
- Signature of the person providing the service (or electronic equivalent) and the person's professional degree, licensure or job title after each chart entry.
- Identify the appropriate service, and service is allowable per the lockout table.

Mental health services, medical support services, and crisis intervention will be documented at every contact.

Information regarding HIV status is not to be written in the document unless it is directly related to treatment. Please review regulations regarding HIV and documentation.

Discharge Summary

A Discharge Summary (Attachment D8) will be included in the client record. A copy of the Discharge Summary must be returned to the MHP office with the final claims. Failure to complete and return Discharge Summary may result in non-payment for final claims.

REQUEST FOR PSYCHIATRIC CONSULTATION/PSYCHIATRIC INPATIENT EVALUATION

Psychiatric Consultation

If psychiatric consultation is required, a provider may contact BHS at (559) 673- 3508, (888) 275-9779 toll free or TTY (800) 735-2929 during business hours and ask to speak to the psychiatrist on duty. If the psychiatrist is not available, the provider will be asked if s/he would like to speak to the LPT/LVN/RN/Nurse Practitioner. A provider may choose to contact the MHP to facilitate consultation.

Inpatient Admissions

When a provider assesses that a Medi-Cal beneficiary may be in need of inpatient psychiatric hospitalization because s/he is:

- A danger to self, or
- A danger to others, or
- Gravely disabled,

the provider will call 911 for emergency services response. The beneficiary will be evaluated upon their arrival.

- Identify himself/herself and the client
- Give the client's phone number and address
- Provide an assessment of the client's current circumstances and status requiring hospitalization

If the beneficiary is placed on a 5150 hold by law-enforcement, the beneficiary will be transported by ambulance to a medical hospital and will be re-evaluated by a crisis worker following medical clearance.

MEDICATION EVALUATION

A provider may call the MHP at (559) 673-3508, (888) 275-9779 (toll free) or TTY (800) 735-2929 to arrange for a Medication Evaluation. The MHP clinician will obtain pertinent information about the individual and arrange for a Medication Evaluation. A Psychiatric Referral form will be completed by MHP staff and sent to Madera BHS Medical Records once a signed Release of Information (Attachment Z) is obtained by the provider from the beneficiary, and forwarded to the MHP. A copy of the beneficiary's current mental health assessment

and the Release of Information will be sent to the appropriate BHS counseling center. All paperwork must be made available to the County psychiatrist prior to the beneficiary's appointment.

Based on the beneficiary's signed Release of Information, BHS will notify the provider that the individual has or has not kept his/her appointment for Medication Evaluation. The psychiatrist will also provide pertinent information to the referring provider when requested.

CONFIDENTIALITY

All information, records, data and data elements pertaining to beneficiaries must be protected by the provider from unauthorized disclosure. In accordance with HIPAA requirements, a Notice of Privacy Practices (Attachment B) will be handed or mailed to all beneficiaries who are referred to a network provider. In addition, a Notice of Privacy Practices will be sent to the provider to be signed by the beneficiary. A copy of the signed HIPAA document is to be placed in the network provider's medical record for the beneficiary. The original signed document should be returned to the MHP with the first claim form.

PAYMENT POLICIES AND PROCEDURES

Payments will be authorized for valid outpatient mental health services claims in accordance with the following service limitations:

- Services were pre-authorized by the MHP in accordance with contract agreements.
- Beneficiary is present during service, missed appointments are not reimbursable.
- All services meet medical necessity.
- Every claim is supported by a progress note and the progress note must accompany the claim prior to submission.
- Outpatient providers must record the provider actual activity and precise number of minutes for each activity. The provider must also record the actual minutes for the service duration, documentation time and/or travel time for each activity. The time required for documentation and travel must be linked to the delivery of the reimbursable services.
- Services were delivered by a contract provider in accordance with contract agreements who is working within his/her scope of practice.
- Inpatient beneficiary was eligible for Medi-Cal reimbursement when services were provided.
- Claims were submitted in accordance with contract agreements.

- A discharge summary (Attachment D8) was sent on or before the final claim for payment.
- A separate claim form (Attachment E3) covering only one fiscal year has been submitted for each beneficiary, which includes the beneficiary's identification number, provider number, time of service, date of service, and duration of each service.
- The first billing was submitted with a completed Assessment (Attachment D5) and the HIPAA Notice of Privacy Practices (Attachment B) signed by the beneficiary or legal guardian.
- The service is allowable per the following lockout table.
- The maximum reimbursement for Medication Support Services in a 24 hour period is 4 hours.

Payments will be mailed to providers in accordance with contract agreements. Payment requests should be made using an MHP, HCFA 1500 (Attachment E3) or an appropriate HIPAA format claim form. Completed forms should be mailed to:

Madera County Behavioral Health Services

Mental Health Plan

P.O. Box 1288 Madera, CA 93639

Reimbursement rates are included in contract provider agreements with the County of Madera.

When a Medi-Cal beneficiary has a third party payer, provider must submit a claim to the MHP along with a copy of the third party payer denial letter or Explanation of Benefits (EOB) in accordance with contract agreements.

QUALITY MANAGEMENT AND UTILIZATION REVIEW

The MHP has the responsibility of assuring that high quality services are provided to Medi-Cal beneficiaries in a cost-effective and efficient manner. The Quality Management Coordinator reviews services and programs of public and private providers in order to ensure provision of meaningful and beneficial services; culturally and linguistically competent services; and appropriate accessibility.

The Quality Management Committee (Attachment L) provides structure for responding to the needs of consumers and providers helping to assure that the MHP provides quality services. The Interagency Quality Improvement Committee (Attachment M) serves to provide continuous monitoring of mental health services to assure that quality services are provided.

The Quality Management Coordinator and other MHP staff will provide on-going consultation regarding medical necessity criteria, patients' rights issues, clinical records, and other quality components. The Quality Management Coordinator will monitor beneficiaries' satisfaction with services they are receiving from providers. (Attachment J)

Provider Grievance and Appeal Procedures

Good provider relations are essential to the effective delivery of mental health services. The following provider grievance and appeal policy and procedures (Attachment F) describes the process by which providers may address their grievance and appeals to the Madera County MHP for resolution. Providers have the right to access the provider appeal process at any time before, during, or after the provider problem resolution process has begun when the grievance concerns a denied or modified request for MHP payment authorization or the processing or payment of a provider's claim to the MHP.

Grievance Process

Provider grievances may address one or more of the following:

- Lack or level of payment for an authorized or emergency claim.
- Delay of payments.
- Lack of information or cooperation by MHP staff.
- Disagreement by the provider with utilization review decisions made by the MHP staff.
- A dispute with the MHP regarding interpretations of provider adverse benefit determination which are reasons for contract terminations.
- Other issues as determined by the provider.

A provider may present a grievance to the MHP Division Manager or designee by telephone, in person, or in writing. The MHP Division Manager or designee will attempt to resolve the grievance. Suggested solutions will be provided to the grievant within 14 calendar days from receipt of the grievance. If the provider is not satisfied with the response, the provider may file an appeal under the circumstances listed below.

Grievance Log

The Behavioral Health Director or designee shall maintain a log of all MHP Grievance Forms and decisions, including disposition of the problems, which shall be submitted to the County Mental Health Quality

Improvement Committee. The Grievance Log information shall include a method for identifying the provider, date of receipt, nature of the problem, time period allowed for resolution, person who received the grievance, person responsible for resolving the grievance, and date for resolution or disposition of the grievance. These records will be open to review by the State Department of Health Care Services (DHCS), and the Federal oversight agency. The log shall document the resolution of the grievance within 90 calendar days of its receipt, or the reason why it could not be resolved.

Appeals (Attachment F)

Denial of Authorization for Services.

A provider may file a written appeal concerning the denial for authorization of specialty mental health services directly to the Behavioral Health Director or designee. The written appeal shall be submitted to the Behavioral Health Director or designee within thirty (30) calendar days of the postmark date of the notification of the denial.

The appeal shall be reviewed and a decision shall be made by the Behavioral Health Director or designee and other qualified staff as assigned by the Behavioral Health Director or designee. The MHP shall use personnel not involved in the initial decision to respond to the provider's appeal.

The Behavioral Health Director or designee will have thirty (30) calendar days from the postmark or fax date of receipt of the appeal to complete an evaluation of the appeal. The provider will be notified in writing if the appeal is upheld or there is a proposed resolution (partial authorization of services or payment) or no basis is found for altering the original decision. This process may also be utilized by any residential treatment program provider. The MHP will respond within 48 hours of receipt of all required materials.

Denial of Claims for Payment.

Providers who receive payment directly from Electronic Data Systems (EDS) may file a written appeal concerning the denial or delay of claims payment for specialty mental health services directly to the fiscal intermediary EDS. The fiscal intermediary will have thirty (30) calendar days from the post mark or fax date of receipt of the appeal to respond in writing to the provider.

Providers who receive payment directly from the MHP may file a written appeal concerning the denial or delay of claims payment directly to the Behavioral Health Director or designee.

The written appeal shall be submitted to the Behavioral Health Director or designee within thirty (30) calendar days of the postmark date of the notification of denial or delay of claims payment.

The provider will be notified in writing if the appeal is upheld or there is a proposed resolution (i.e., partial payment) or no basis is found for altering the original decision. If the provider appeal is upheld or partial payment is approved, the Behavioral Health Director or designee will have fifteen (15) business days to process the claim for payment to the provider.

Contact Person

The contact person for all beneficiary and provider problems and appeals is: Quality Management Coordinator
Madera County Behavioral Health Services

P.O. Box 1288 Madera, CA 93639-1288

(559) 673-3508; FAX (559) 675-7758

TTY (800) 735-2929

PROVIDER CREDENTIALING PROCESS

Madera County MHP ensures that members receive services consistent with recognized community standards from qualified mental health practitioners. All providers must have current documentation of qualifications which adhere to the MHP standards.

Providers will be re-credentialed every two years and monitored to insure standards of the MHP are met. It is the responsibility of all providers to continue to meet the standards set forth by the MHP. Failure to do so may be grounds for suspension or revocation of credentialing by BHS. If a clinician fails to meet the standards set forth by the Board of Behavioral Science Examiners his/her clinical privileges with Madera County will be revoked. See attached copies of credentialing procedures. (Attachment X)

PROVIDER UPDATES

Provider letters will be mailed to contracted providers when an update is required regarding clinical, administrative, or financial policy changes. All changes outlined in the letters have the authority of policy and are binding, as indicated, on County and providers.

BENEFICIARY RIGHTS

Madera County Medi-Cal beneficiaries will be informed of guaranteed rights for beneficiaries including assurance that treatment will not be adversely affected as a result of their exercising their rights. MHP will mail beneficiaries referred to a Network Provider a copy of "Consumer Rights and Problem Resolution Guide" within two (2) working days of referral. (Attachment N1, N2)

ADVANCE DIRECTIVES

All adult Madera County Medi-Cal beneficiaries will be given information concerning their rights under California State Law regarding Advance Medical Directives. MHP will mail beneficiaries referred to a Network Provider a copy of "Your right to Make Decisions about Medical Treatment". The MHP will send to the Contract Provider a copy of Advance Directives Documentation of Change form to be placed in beneficiary's medical record. (Attachment Y)