

**MADERA COUNTY
BEHAVIORAL HEALTH SERVICES**

POLICY NO.: MHP 33:00

SUBJECT: INTENSIVE AND REHABILITATIVE DAY TREATMENT FOR YOUTH IN
OUT-OF-COUNTY PLACEMENT

POLICY:

Intensive and/or Rehabilitative Day treatment services will be provided to Madera County youth in out of county placements.

PURPOSE:

To provide a structure that delineates an Intensive and Rehabilitative Day Treatment program for youth, that meets State criteria.

DEFINITION:

- I. "Day Treatment Intensive and Rehabilitative" means structured, multi-disciplinary programs of therapy which may be an alternative to hospitalization, avoid placement in a more restrictive setting, or maintain the beneficiary in a community setting, with services available at least three hours and less than twenty-four hours each day the program is open. Services must be made available during the course of the therapeutic milieu for at least an average of three hours per day for full-day programs and an average of two hours per day for half-day programs. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral. (Please note that day treatment intensive can also include components that occur outside the therapeutic milieu, e.g., family therapy, travel, documentation, and contacts with significant support persons.) Day Treatment Intensive and Rehabilitative must include:
 - A. Process groups to help clients develop the skills necessary to deal with their individual problems/issues by using the group process to provide peer interaction and feedback in developing problem-solving strategies and to assist one another in resolving behavioral and emotional problems.
 - B. Skill Building Groups to help clients identify barriers/obstacles related to their psychiatric/psychological experiences and, through the course of group interaction, become better able to identify skills that address symptoms and behaviors and to increase adaptive behaviors.
 - C. Adjunctive Therapies that allow clients to participate in non-traditional therapy that utilizes self-expression (art, recreation, dance, music, etc.) as the therapeutic intervention. Participants do not need to have any level of skill in the area of self-expression, but rather be able to utilize the modality to develop or enhance skills

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directed towards client plan goals.

- D. One contact (face-to-face or by an alternative method, e.g., e-mail, telephone, etc.) per month is required with a family member, caregiver or other significant support person identified by an adult client, or one contact per month with the legally responsible adult for a client who is a minor. The contacts and involvement should focus on the role of the significant support person in supporting the client's community reintegration.
- E. Must have an established protocol for responding to clients experiencing a mental health crisis. The protocol must assure the availability of appropriately trained and qualified staff and include agreed upon procedures for addressing crisis situations. If clients will be referred to crisis services outside the day treatment intensive or day rehabilitation program, the day treatment intensive or day rehabilitation staff must have the capacity to handle the crisis until the client is linked to the outside crisis services.
- F. Must have and make available to clients and, as appropriate, to their families, caregivers or significant support persons a detailed written weekly schedule that identifies when and where the service components of program will be provided and by whom. The written weekly schedule will specify the program staff, their qualifications, and the scope of their responsibilities.
- G. Intensive Day Treatment must also include psychotherapy using psychosocial methods within a professional relationship to assist the person or persons to achieve a better psychosocial adaptation, to acquire greater human realization of psychosocial potential and adaptation, to modify internal and external conditions that affect individuals, groups, or communities in respect to behavior, emotions, and thinking, in respect to their intrapersonal and interpersonal processes. Psychotherapy is provided by licensed, registered, or waived staff practicing within their scope of practice. Psychotherapy does not include physiological interventions, including medication intervention.

II. Day Treatment Intensive and Rehabilitative Staffing Requirements:

- A. At a minimum there must be an average ratio of at least one person from the following list providing Day Treatment Intensive services to eight beneficiaries or other clients in attendance during the period the program is open. Day Treatment Intensive requires that one staff person be present at all times whose- scope of practice includes psychotherapy. Day Treatment Rehabilitation services must have one person from the following list to ten beneficiaries or other clients in attendance during the period the program is open.
 - 1. Physicians.
 - 2. Psychologists or related waived/registered professionals.
 - 3. Licensed Clinical Social Workers or related waived/registered professionals.

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4. Marriage, Family and Child Counselors or related waived/registered professionals.
 5. Registered Nurses.
 6. Licensed Vocational Nurses.
 7. Psychiatric Technicians.
 8. Occupational Therapists.
 9. Mental Health Rehabilitation Specialists as defined in Section 630.
- B. Persons who are not solely used to provide Day Treatment Intensive services may be utilized according to program need, but shall not be included as part of the above ratio formula. The MHP shall ensure that there is a clear audit trail of the number and identity of the persons who provide Day Treatment Intensive services and function in other capacities.
- C. Persons providing services in Day Treatment Intensive and Day Treatment Rehabilitation programs serving more than 12 clients shall include at least one person from each of two of the following groups (this includes one staff person whose scope of practice is psychotherapy for Intensive Day Treatment):
1. Physicians.
 2. Psychologists or related waived/registered professionals.
 3. Licensed Clinical Social Workers or related waived/registered professionals.
 4. Marriage, Family and Child Counselors or related waived/registered professionals.
 5. Registered Nurses.
 6. Licensed Vocational Nurses.
 7. Psychiatric Technicians.
 8. Occupational Therapists.
 9. Mental Health Rehabilitation Specialists as defined in Section 630.

III. Documentation Requirements:

- A. An Assessment and Client Plan of Care must be completed every 90 days for clients in Day Treatment Intensive. Clients in Day Treatment Rehabilitative require an Assessment and Client Plan of Care every 180 days.
- B. Progress notes must be contained in the client record and related to the client's progress in treatment. Progress notes must include, but are not limited to:
1. Timely documentation of relevant aspects of client care.

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2. Signature of the person providing the service (or electronic equivalent); the person's degree, licensure, or job title.
 3. Date service was provided.
 4. Will be legible.
 5. Will document referrals to community resources and other agencies when appropriate.
 6. Will document follow-up care, or as appropriate, a discharge summary.
- C. Progress notes will be documented at the frequency noted below:
1. Mental Health, medical support, and crisis intervention services will be documented at every service contact.
 2. Day Treatment Intensive notes must be completed daily.
 3. Intensive Day treatment Summary and Rehabilitative Day Treatment notes must be completed weekly.

PROCEDURES

- I. Day Treatment Intensive and Rehabilitative Assessment
- A. Out of county clinical provider will complete a full assessment to determine if the beneficiary meets criteria for specialty mental health services.
 - B. If it is determined that the youth would benefit from an Intensive Day Treatment program, the clinician will notify MHP by phone (559-675-7850 or 1-888-275-9779) requesting authorization. The clinician will submit Assessment and Client Plan of Care to MHP within 24 hours.
 - C. Initial services will be authorized for no longer than 3 months for Day Treatment Intensive and 6 months for Day Treatment Rehabilitative.
- II. Admission Criteria
- A. Initial authorization by MHP will be for 3 months. Reauthorization will be a maximum of every 3 months for Day Treatment Intensive and every 6 months for Day Treatment Rehabilitative.
 - B. Adolescents who exhibit a serious mental/emotional disorder and meet Specialty Mental Health Medi-cal medical necessity criteria.
 - C. Have a functional impairment as a result of a mental/emotional disorder and a GAF below 50.
 - D. The functional impairment must result from a Medi-cal "included" diagnosis. See Attachment 1 (Medical Necessity Criteria).
 - E. The need for this level of care is warranted by:
 1. Previous treatment failures and continued decompensation.



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2. Prevention of possible hospitalization and/or placement at a higher level of care.
- III. Assessment and Client Plan of Care (Day Treatment Intensive and Rehabilitative)
- A. Assessment must include the following:
1. Relevant physical health information.
 2. Presenting problems and relevant conditions affecting the client's physical and mental health status (living conditions, daily activities, social support, school).
 3. Will describe client's strengths that will facilitate success in treatment.
 4. Risk factors must be documented. (suicide, homicide, drug usage, physical, sexual abuse, gang involvement).
 5. Current meds, dosages, prescribing physician, and date of initial prescription.
 6. Self report of allergies, adverse reactions to medications and food, or lack thereof.
 7. Mental health history will be documented, including previous treatment dates, providers, therapeutic interventions and responses, sources of clinical data (including lab results), relevant family.
 8. Pre-natal and peri-natal events and complete developmental history.
 9. Past and present use of tobacco, alcohol, caffeine, prescribed, over the counter, and illicit substances.
 10. Mental status examination.
 11. 5 AXIS Diagnosis from the most current DSM, which must be consistent with presenting problem(s), history, mental status evaluation, and/or other assessment data.
 12. Relevant cultural information.
 13. Clinician completing Assessment must sign and date.
- B. Client Plan of Care
1. Will have specific observable and/or quantifiable long-term goals.
 2. Specific objectives that will document how the client will achieve the long-term goals.
 3. Modalities and proposed frequency of treatment will be clearly stated.
 4. Interventions will specifically address treatment objectives.
 5. Proposed duration of treatment will be clearly documented with each

objective.

6. Client strengths and barriers to treatment will be documented.
7. Clinician completing Plan of Care must sign and date.
8. Client and/or legal guardian must sign as evidence of involvement in treatment planning.
9. If the client is in need of additional specialty mental health services that can only be provided outside the scheduled day treatment hours, the clinician must document the "modality and frequency" of the service requested along with "after day treatment" specified to identify that the services are being requested for after day treatment hours on the Client Plan of Care. The documentation for this additional specialty mental health service must support the request.
10. All additional Day Treatment Services must have prior authorization in order to receive payment. If a CPOC has already been approved, then the "Day Treatment CPOC Addendum" form will be used.

AUTHORIZATION

1. The MHP will review forms for medical and service necessity for treatment. If client meets criteria for Intensive Day Treatment or Rehabilitative Day Treatment, services will be authorized for 3 months.
2. The MHP will review and return authorized forms to the provider within 24 hours of receipt by MHP.
3. When the client no longer meets medical necessity and service criteria for Intensive or Rehabilitative Day Treatment, the clinician is expected to discharge the client from the program.
4. All Authorizations that are received by the MHP prior to 5:00 p.m. on a working day will be reviewed and returned by 5:00 PM the next business day.

REAUTHORIZATION

1. If the clinician determines the client is in need of Rehabilitative or Intensive Day Treatment beyond the initially authorized 3 months, the clinician must complete a new Day Treatment Intensive Assessment and Client Plan of Care. These forms must be submitted to the MHP two weeks prior to the expiration of the first authorization period.
Reauthorization will be a maximum of every 3 months for Day Treatment Intensive and every 6 months for Day Treatment Rehabilitative.
2. Client and/or legal guardian must sign as evidence of involvement in treatment planning.
3. If it is determined by the MHP that the client does not meet service criteria, an NOA-B will be sent. (See NOA-B Policies and Procedures Attachment 2).



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4. The Client Plan of Care must include discharge planning to out patient mental health service directly through MHP.

RETROSPECTIVE CHART REVIEW

1. A minimum of 1 chart and a maximum of 10% of Madera County client charts will be reviewed each quarter.
2. If a retrospective review of the documentation does not support the service criteria for treatment subsequent to an MHP review, charges for the specific days that do not document medical and service necessity will be disallowed.

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Medical Necessity For Specialty Mental Health Services That Are The Responsibility Of Mental Health Plans

Must have *all, A, B and C*:

A. Diagnoses

Must have one of the following DSM IV diagnoses, which will be the focus of the intervention being provided:

Included Diagnosis:

- Pervasive Development Disorders, except Autistic Disorder which is excluded.
- Attention Deficit and Disruptive Behavior Disorders
- Feeding & Eating Disorders of Infancy or Early Childhood
- Elimination Disorders
- Other Disorders of Infancy, Childhood or Adolescence
- Schizophrenia & Other Psychotic Disorder
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Paraphilias
- Gender Identify Disorders
- Eating Disorders
- Impulse-Control Disorders Not Elsewhere Classified
- Adjustment Disorders
- Personality Disorders, excluding Antisocial Personality Disorder
- Medication-Induced Movement Disorders (related to other included diagnoses).

B. Impairment Criteria

Must have *one* of the following as a result of the mental disorder(s) identified in the diagnostic ("A") criteria; Must have *one, 1, 2 or 3*:

- 1 A significant impairment in an important area of life functioning, *or*
- 2 A probability of significant deterioration in an important area of life functioning, *or*
- 3 Children also qualify if there is a probability the child will not progress developmentally as individually appropriate.

Children covered under EPSDT qualify if they have a mental disorder which can be corrected or ameliorated (current DHS EPSDT regulations also apply).

C. Intervention Related Criteria

Must have *all, 1, 2 and 3* below:

- 1 The focus of proposed intervention is to address the condition identified in impairment criteria "B" above *and*
- 2 It is expected the beneficiary will benefit from the proposed intervention by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning, and/or for children it is probable the child will progress developmentally as individually appropriate (or if covered by EPSDT can be corrected or ameliorated), *and*
- 3 The condition would not be responsive to physical health care based treatment.

Excluded Diagnosis:

- Mental Retardation
- Learning Disorder
- Motor Skills Disorder
- Communications Disorders
- Autistic Disorder, Other Pervasive Developmental Disorders are included.
- Tic Disorders
- Delirium, Dementia, and Amnesic and Other Cognitive Disorders
- Mental Disorders Due to a General Medical Condition
- Substance-Related Disorders
- Sexual Dysfunctions
- Sleep Disorders
- Antisocial Personality Disorder
- Other Conditions that may be a focus of clinical attention, except Medication induced Movement Disorders which are included.

A beneficiary may receive services for an included diagnosis when an excluded diagnosis is also present.

EPSDT beneficiaries with an included diagnosis and a substance related disorder may receive specialty mental health services directed at the substance use component. The intervention must be consistent with, and necessary to the attainment of, the specialty MH treatment goals.

Medical Necessity Criteria

Title 9, California Code of Regulations, Chapter 11, Medi-Cal Specialty Mental Health Services

Section 1830.210

Medical Necessity Criteria for MHP Reimbursement for Specialty Mental Health Services for Eligible Beneficiaries Under 21 Years of Age.

(a) For beneficiaries under 21 years of age who are eligible for EPSDT supplemental specialty mental health services, and who do not meet the medical necessity requirements of Section 1830.205(b)(2)-(3), medical necessity criteria for specialty mental health services covered by this Subchapter shall be met when all of the following exist:

- (1) The beneficiary meets the diagnosis criteria in Section 1830.205(b)(1),
- (2) The beneficiary has a condition that would not be responsive to physical health care based treatment, and
- (3) The requirements of Title 22, Section 51340(e)(3)(A) are met with respect to the mental disorder; or, for targeted case management services, the service to which access is to be gained through case management is medically necessary for the beneficiary under Section 1830.205 or under Title 22, Section 51340(e)(3)(A) with respect to the mental disorder and the requirements of Title 22, Section 51340(f) are met.

(b) The MHP shall not approve a request for an EPSDT supplemental specialty mental health service under this Section or Section 1830.205 if the MHP determines that the service to be provided is accessible and available in an appropriate and timely manner as another specialty mental health service covered by this Subchapter and the MHP provides or arranges and pays for such a specialty mental health service.

(c) The MHP shall not approve a request for specialty mental health services under this Section in home and community based settings if the MHP determines that the total cost incurred by the Medi-Cal program for providing such services to the beneficiary is greater than the total cost to the Medi-Cal program in providing medically equivalent services at the beneficiary's otherwise appropriate institutional level of care, where medically equivalent services at the appropriate level are available in a timely manner, and the MHP provides or arranges and pays for the institutional level of care if the institutional level of care is covered by the MHP under Section 1810.345, or arranges for the institutional level of care, if the institutional level of care is not covered by the MHP under Section 1810.345. For the purpose of this Subsection, the determination of the availability of an appropriate institutional level of care shall be made in accordance with the stipulated settlement in T.L. v. Belshe.

Section 1830.205

Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services.

(a) The following medical necessity criteria determine Medi-Cal reimbursement for specialty mental health services that are the responsibility of the MHP under this Subchapter, except as specifically provided.

(b) The beneficiary must meet criteria outlined in Subsections (1)-(3) below to be eligible for services:

(1) Have one of the following diagnoses in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, Fourth Edition (1994), published by the American Psychiatric Association:

(A) Pervasive Developmental Disorders, except Autistic Disorders

(B) Disruptive Behavior and Attention Deficit Disorders

(C) Feeding and Eating Disorders of Infancy and Early Childhood

(D) Elimination Disorders

(E) Other Disorders of Infancy, Childhood, or Adolescence

(F) Schizophrenia and other Psychotic Disorders, except Psychotic Disorders due to a General Medical Condition

(G) Mood Disorders, except Mood Disorders due to a General Medical Condition

(H) Anxiety Disorders, except Anxiety Disorders due to a General Medical Condition

(I) Somatoform Disorders

(J) Factitious Disorders

(K) Dissociative Disorders

(L) Paraphilias

(M) Gender Identity Disorder

(N) Eating Disorders

(O) Impulse Control Disorders Not Elsewhere Classified

(P) Adjustment Disorders

(Q) Personality Disorders, excluding Antisocial Personality Disorder

(R) Medication-Induced Movement Disorders related to other included diagnoses.

(2) Have at least one of the following impairments as a result of the mental disorder(s) listed in Subsection (b)(1) above:

(A) A significant impairment in an important area of life functioning.

(B) A reasonable probability of significant deterioration in an important area of life functioning.

(C) Except as provided in Section 1830.210, a reasonable probability a child will not progress developmentally as individually appropriate. For the purpose of this Section, a child is a person under the age of 21 years.

(3) Meet each of the intervention criteria listed below:

(A) The focus of the proposed intervention is to address the condition identified in Subsection (b)(2) above.

(B) The expectation is that the proposed intervention will:

1. Significantly diminish the impairment, or
2. Prevent significant deterioration in an important area of life functioning, or
3. Except as provided in Section 1830.210, allow the child to progress developmentally as individually appropriate.
4. For a child who meets the criteria of Section 1830.210(1), meet the criteria of Section 1830.210(b) and (c).

(C) The condition would not be responsive to physical health care based treatment.

(c) When the requirements of this Section or Section 1830.210 are met, beneficiaries shall receive specialty mental health services for a diagnosis included in Subsection (b)(1) even if a diagnosis that is not included in Subsection (b)(1) is also present.

**MADERA COUNTY
BEHAVIORAL HEALTH SERVICES**

POLICY NO.: MHP 22:00

SUBJECT: NOTICE OF ACTION – B

POLICY:

A Notice of Action - B (NOA-B) shall be mailed or delivered to the Medi-Cal beneficiary and provider when the Mental Health Plan (MHP) takes an action, other than approval, on a request by a provider for any Medi-Cal specialty mental health service not already provided and previously authorized by MHP.

PURPOSE:

To ensure the beneficiary and provider are notified in a timely manner when specialty mental health services are not approved as requested by the provider.

PROCEDURE:

- A. The original NOA-B will be sent to the beneficiary and a copy mailed to the provider and placed in MHP files within three (3) working days of the decision by MHP for the following:
 - 1. Modification of Services
MHP approves a different type of service or a lower frequency than requested.
 - 2. Denial of Services Requested
MHP determines that a medical necessity has not been met and does not approve the requested services.
 - 3. Referral of More Than 30 Days
If MHP, after 30 days of the request for service, has been unable to obtain sufficient information to make a decision whether to approve the requested services.
- B. When MHP changes or discontinues a current authorization, MHP will mail the NOA-B to the beneficiary or authorized representative ten days in advance of the action.
- C. The NOA-B will inform the beneficiary of his/her right to a State Fair Hearing after the Appeal Process has been exhausted.
- D. The provider may choose to file a grievance.

Attachment

Approved by BHS Director: Signature on File	Date: 5-30-08	Effective Date: 10-01-03	Revision Date: 11-09-04, 8-22-07, 4-1-08
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Madera County Behavioral Health Services

Medi-Cal Specialty Mental Health Services Program NOTICE OF ACTION

Date: _____

To: _____, Medi-Cal Number: _____

The Mental Health Plan for Madera County has denied changed your provider's request for payment for the following service(s):

The request was made by (provider name) _____. The original request from your provider was dated _____.

The Mental Health Plan took this action based on information from your provider for the reason checked below:

- Your mental health condition does not meet the medical necessity criteria for psychiatric inpatient hospital services or related professional services (Title 9, California Code of Regulations (CCR), Section 1820.205).
- Your mental health condition does not meet the medical necessity criteria for specialty mental health services other than psychiatric inpatient hospital services for the following reason (Title 9, CCR, Section 1830.205): _____
- The service requested is not covered by the Mental Health Plan (Title 9, CCR, Section 1810.345).
- The Mental Health Plan requested additional information from your provider that the plan needs to approve payment of the proposed service. To date, the information has not been received.
- The Mental Health Plan will pay for the following service(s) instead of the service requested by your provider, based on the available information on your mental health condition and service needs: _____
- Other: _____

If you don't agree with the plan's decision, you may:

1. File an appeal with your Mental Health Plan. To do this, you may call and talk to a representative of your Mental Health Plan at the telephone number below, write to the Madera County Mental Health Plan at the address below or follow the directions in the information brochure the Mental Health Plan has given you. You must file an appeal within 90 days of the date of this notice. In most cases the Mental Health Plan must make a decision on your appeal within 45 days of your request. You may request an expedited appeal, which must be decided within 3 working days, if you believe that a delay would cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions. You can request that your services stay the same until an appeal decision is made. To keep your services you must file an appeal within 10 days of the date of this notice or before the effective date of the change in services, whichever is later. The services requested were previously approved by the plan for the period _____. The effective date for the change in these services is _____.
2. If you are dissatisfied with the outcome of your appeal, you may request a state hearing which may allow services to continue while you wait for the hearing. The other side of this notice explains how to request a hearing. You can request that your services stay the same until a hearing decision is made. To keep your services you must file an appeal within 10 days of the date of this notice or before the effective date of the change in services, whichever is later. The services requested were previously approved by the plan for the period _____. The effective date for the change in these services is _____. The services may continue while you wait for a resolution of your hearing.
3. You may ask the plan to arrange for a second opinion about your mental health condition. To do this, you may call and talk to a representative of your Mental Health Plan at:

559-675-7850

toll free: 888-275-9779

or write to:

Madera County Mental Health Plan
PO Box 1288
Madera, CA 93639

YOUR HEARING RIGHTS

You only have 90 days to ask for a hearing. The 90 days start either:

1. The day after we personally gave you the Mental Health Plan's appeal decision notice, OR
2. The day after the postmark date of this Mental Health Plan's appeal decision notice.

Expedited State Hearings

It usually takes about 90 days from the date of your request to make a hearing decision. If you think this timing will cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions, you may request an expedited state hearing. **To request an expedited hearing, please check the first box in the right hand column of this page under HEARING REQUEST and include the reason why you are requesting an expedited hearing.** If your expedited hearing request is approved, a hearing decision will be issued within three working days of the date your request is received by the State Hearings Division.

To Keep Your Same Services While You Wait for A Hearing

- You must ask for a hearing within 10 days from the date the Mental Health Plan's appeal decision notice was mailed or personally given to you or before the effective date of the change in services, whichever is later.
- Your Medi-Cal mental health services will stay the same until a final hearing decision is made which is adverse to you, you withdraw your request for a hearing, or the time period or service limits for your current services expire, whichever happens first.

State Regulations Available

State regulations, including those covering state hearings, are available at your local county welfare office.

To Get Help

You may get free legal help at your local legal aid office or other groups. You can ask about your hearing rights or free legal aid from the Public Inquiry and Response Unit:

Call toll free: 1-800-952-5253
If you are deaf and use TDD, call: 1-800-952-8349

Authorized Representative

You can represent yourself at the state hearing. You can also be represented by a friend, an attorney or anyone else you choose. You must arrange for this representative yourself.

Information Practices Act Notice (California Civil Code Section 1798, et. seq.) The information you are asked to write in on this form is needed to process your hearing request. Processing may be delayed if the information is not complete. A case file will be set up by the State Hearings Division of the Department of Social Services. You have the right to examine the materials that make up the record for decision and may locate this record by contacting the Public Inquiry and Response Unit (phone number shown above). Any information you provide may be shared with the Mental Health Plan, the State Departments of Health Services and Mental Health and with the U.S. Department of Health and Human Services (Authority: Welfare and Institutions Code, Section 14100.2)

HOW TO ASK FOR A STATE HEARING

The best way to ask for a hearing is to fill out this page. Make a copy of the front and back for your records. Then send this page to:

State Hearings Division
California Department of Social Services
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430

Another way to ask for a hearing is to call 1-800-952-5253. If you are deaf and use TDD, call 1-800-952-8349.

HEARING REQUEST

I want a hearing because of a Medi-Cal related action by the Mental Health Plan of Madera County.

Check here if you want an expedited state hearing and include the reason below.

Here's why: _____

Check here and add a page if you need more space.

My name (print): _____

My Social Security Number: _____

My Address (print): _____

My phone number: (____) _____

My signature: _____

Date: _____

I need an interpreter at no cost to me. My language or dialect is: _____

I want the person named below to represent me at this hearing. I give my permission for this person to see my records and to come to the hearing for me.

Name _____

Address _____

Phone number: _____



Condado de Madera Departamento de Salud Mental

AVISO De ACCION (NOA-B)

Fecha: _____

A: _____, Numero de Medi-Cal _____

El plan de salud mental del Departamento de Salud Mental del Condado de Madera ha negado o cambiado la demanda de pago por el proveedor por el siguiente servicio: _____

La petición la hizo (nombre del proveedor): _____

La petición original de su proveedor tiene fecha de: _____

El plan de salud mental tomo esta acción basado en información dada por su proveedor como indican los razones a continuación:

- Su condición de salud mental como la describió su proveedor no coincidió con los criterios de la necesidad médica para servicios de hospital psiquiátrico de pacientes internos o servicios profesionales relacionados (Título 9, California Código de Regulaciones (CCR), Sección 1820.205).
- Su condición de salud mental como la describió su proveedor no coincidió con los criterios de la necesidad médica para servicios de especialidad de salud mentales con excepción de servicios de hospital psiquiátrico para pacientes internos por la siguiente razón (Título 9, CCR, Sección 1830.205):
 - El servicio solicitado no esta cubierto por el plan de salud mental. (Title 9, CCR, Section 1810.345).
 - El plan de salud mental solicita información adicional de su proveedor que el plan necesita para aprobar el pago del propuesto servicio. Hasta la fecha no se ha recibido información.
 - El plan de salud mental pagara el siguiente servicio o servicios, en lugar de los servicios solicitados por su proveedor basándose en la información disponible sobre su condición de salud mental y la necesidad de servicios.
- Otro: _____

Si no esta de acuerdo con la decisión del plan de salud mental, usted puede:

1. Archivar una apelación con el plan de salud mental. Para hacer esto, usted puede llamar y hablar con un representante del plan de salud mental o escriba a la dirección disponible en esta pagina. También puede seguir las direcciones en el folleto de información que el plan de salud mental le ha dado. Debe archivar una apelación dentro de 90 días de la fecha de este aviso. En la mayoría de casos el plan de la salud mental debe hacer una decisión de su apelación dentro de 45 días de su petición. Puede pedir una apelación expeditiva (apresurada), que se debe decidir dentro de 3 días laborales, si cree que una demora causaría problemas serios con su salud mental, incluso problemas con su capacidad de ganar, mantener o recuperar funciones importantes de la vida. Puede pedir que sus servicios se quedan donde mismo hasta que se haga una decisión de la apelación. Para mantener sus servicios debe archivar una apelación dentro de 10 días de la fecha de este aviso o antes de la fecha vigente del cambio en servicios, cualquiera sea más tarde. Los servicios pedidos se aprobaron previamente por el plan, por el período _____. La fecha vigente por el cambio en estos servicios es _____.
2. Si está en desacuerdo con el resultado de su apelación, puede pedir una audiencia estatal, lo cual dejara continuar los servicios mientras espere la audiencia. El otro lado de este aviso explica cómo pedir una audiencia.
3. Puede pedir que sus servicios se queden iguales hasta que se haga una decisión en la audiencia. Para mantener sus servicios debe archivar una apelación dentro de 10 días de la fecha de este aviso o antes de la fecha vigente del cambio en servicios, cualquiera que sea más tarde. Los servicios pedidos se aprobaron previamente por el plan, por el período _____. La fecha vigente por el cambio en estos servicios es _____. Los servicios continuaran mientras espera una resolución de su audiencia. Puede pedir que el plan haga arreglos para una segunda opinión sobre su condición de la salud mental. Para hacer esto, puede llamar y hablar con un representante del plan de salud mental o escriba a la dirección disponible en esta pagina.

559-675-7850
Llamada gratis: 888-275-9779

o escriba a:
Plan de Salud Mental
PO Box 1288
Madera, CA 93639

SUS DERECHOS de una AUDIENCIA

Usted tiene 90 días para pedir una audiencia. Los 90 días empiezan:

1. El día después de que personalmente le dimos el aviso de la decisión de la apelación del plan de salud mental, o
2. El día después de la fecha del sello postal del aviso de la decisión de la apelación del plan de salud mental.

Audiencias Estatales Expositivas (Apresuradas)

Normalmente toma aproximadamente 90 días de la fecha de su petición para tomar una decisión de audiencia. Si piensa que éste tiempo le causará problemas serios con su salud mental, incluso problemas con su habilidad de progresar, mantener o recobrar funciones importantes de la vida, puede pedir una audiencia estatal apresurada. **Para pedir una audiencia apresurada, favor de marcar la 1ª caja en la columna de la mano derecha de esta página bajo PETICION PARA PEDIR UNA AUDIENCIA e incluya la razón porqué pide una audiencia apresurada.** Si su petición de audiencia apresurada se aprueba, se emitirá una decisión de audiencia dentro de tres días laborales de la fecha que su petición es recibida por la Division Estatal de Audiencias.

Para Mantener Sus Mismos Servicios Mientras espera Una Audiencia

- Debe pedir una audiencia dentro de 10 días de la fecha en que se le mandó por correo el aviso de la decisión de la apelación del plan de salud mental o personalmente dado a usted o antes de la fecha vigente del cambio en servicios, o lo que sea más tarde.
- Sus servicios de Medi-Cal de salud mental se quedarán igual hasta que se haga una decisión final de la audiencia el cual está adverso a usted, usted retire su demanda por una audiencia, o el período de tiempo o límites de servicio por sus presentes servicios se vence, cualquier de estos pase primero.

Reglamentos Estatales Disponibles

Reglamentos estatales, incluso aquellos que cubren audiencias estatales, están disponibles en su oficina local de servicios sociales del condado.

Para Obtener Ayuda

Puede obtener ayuda legal gratis en la oficina de ayuda legal o de otros grupos. Puede preguntar sobre sus derechos de audiencia o ayuda legal gratis a la Unidad Publica de Investigaciones y Respuestas al 1-800-952-5253. Si está sordo(a), llame al 1-800-952-8349.

Representante Autorizado

Puede representarse usted mismo en la audiencia estatal. Puede ser representado también por un amigo, un abogado o algún otro que elija. Debe hacer arreglos para este representante usted mismo.

Aviso del Acto De las Prácticas de la Información ('Information Practices Act Notice' [California Civil Code Section 1798, et. seq.]).

La información que se pide en esta forma se necesita para procesar su petición de audiencia. Se retrasa el proceso si la información no es completa. Se establecerá un archivo de causa por la Division Estatal de Audiencias del Departamento de Servicios Sociales. Tiene el derecho de examinar los materiales que componen el registro para decisión y puede localizar este registro con ponerse en contacto con la Unidad Publica de Investigaciones y Respuestas (número de teléfono arriba). Cualquier información que provee se comparte con el plan de la salud mental, el Departamento Estatal de Servicios de Salud y de Salud Mental y con el Departamento de Salud y Servicios Humanos de los Estados Unidos (Autorización: Welfare and Institutions Code, Section 14100.2)

COMO PEDIR UNA AUDIENCIA ESTATAL

La mejor manera de pedir una audiencia es completar esta página. Haga una copia, frente e inverso para sus archivos. Envíe esta página a:

Division Estatal de Audiencias
Departamento de Servicios Sociales del Estado de California
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430

Otra manera de pedir una audiencia es llamar 1-800-952-5253. Si es sordo(a), llama al 1-800-952-8349.

PETICION PARA PEDIR UNA AUDIENCIA

Quiero una audiencia debido a una acción relacionada con Medi-Cal por el Plan de Salud Mental del condado de Madera.

Anote aquí si quiere que la audiencia estatal sea expeditiva (apresurada) e incluya la razón abajo.

Anote aquí y agrega una pagina si tiene necesidad de más espacio.

Mi nombre (imprima): _____

Mi Número de seguro social: _____

Mi Dirección (imprima): _____

Mi número telefónico: (_____) _____

Mi firma: _____

Fecha: _____

Requiero un intérprete sin ningún costo para mí. Mi idioma o dialecto es _____.

Quiero que la persona nombrada abajo me represente en esta audiencia. Doy mi permiso para que esta persona vea mis archivos y se presente el la audiencia por mí parte.

Nombre: _____

Dirección: _____

Número del teléfono: _____