ATTATCHMENTS

FOR THE

MANAGED CARE

MANUAL

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ATTACHMENT A

Medical Necessity Criteria

MHP 33.00

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).

Excluded Diagnosis:

- Mental Retardation
- Learning Disorder
- Motor Skills Disorder
- Communications Disorders
- Autistic Disorder, Other Pervasive Developmental Disorders are included.
- Tic Disorders
- Delirium, Dementia, and Amnestic 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.

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.

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-IVE, 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.

ATTACHMENT B

HIPAA Notice

Of Privacy

Practices

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

[*45 CFR 164.520*]

Background

The HIPAA Privacy Rule gives individuals a fundamental new right to be informed of the privacy practices of their health plans and of most of their health care providers, as well as to be informed of their privacy rights with respect to their personal health information. Health plans and covered health care providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices. The notice is intended to focus individuals on privacy issues and concerns, and to prompt them to have discussions with their health plans and health care providers and exercise their rights.

How the Rule Works

General Rule. The Privacy Rule provides that an individual has a right to adequate notice of how a covered entity may use and disclose protected health information about the individual, as well as his or her rights and the covered entity's obligations with respect to that information. Most covered entities must develop and provide individuals with this notice of their privacy practices.

The Privacy Rule does not require the following covered entities to develop a notice:

- Health care clearinghouses, if the only protected health information they create or receive is as a business associate of another covered entity. See 45 CFR 164.500(b)(1).

- A correctional institution that is a covered entity (e.g., that has a covered health care provider component).

- A group health plan that provides benefits only through one or more contracts of insurance with health insurance issuers or HMOs, and that does not create or receive protected health information other than summary health information or enrollment or disenrollment information.

See 45 CFR 164.520(a).

Content of the Notice. Covered entities are required to provide a notice in *plain language* that describes:

- How the covered entity may use and disclose protected health information about an individual.

- The individual's rights with respect to the information and how the individual may exercise these rights, including how the individual may complain to the covered entity.

- The covered entity's legal duties with respect to the information, including a statement that the covered entity is required by law to maintain the privacy of protected health information.

- Whom individuals can contact for further information about the covered entity's privacy policies.

The notice must include an effective date. See 45 CFR 164.520(b) for the specific requirements for developing the content of the notice.

A covered entity is required to promptly revise and distribute its notice whenever it makes material changes to any of its privacy practices. See 45 CFR 164.520(b)(3), 164.520(c)(1)(i)(C) for health plans, and 164.520(c)(2)(iv) for covered health care providers with direct treatment relationships with individuals.

<u>Providing the Notice.</u>

- A covered entity must make its notice available to any person who asks for it.

- A covered entity must prominently post and make available its notice on any web site it maintains that provides information about its customer services or benefits.

- *Health Plans* must also:

    - Provide the notice to individuals then covered by the plan no later than April 14, 2003 (April 14, 2004, for small health plans) and to new enrollees at the time of enrollment.
    - Provide a revised notice to individuals then covered by the plan within 60 days of a material revision.
    - Notify individuals then covered by the plan of the availability of and how to obtain the notice at least once every three years.

- *Covered Direct Treatment Providers* must also:

- ▸ Provide the notice to the individual no later than the date of first service delivery (after the April 14, 2003 compliance date of the Privacy Rule) and, except in an emergency treatment situation, make a good faith effort to obtain the individual's written acknowledgment of receipt of the notice. If an acknowledgment cannot be obtained, the provider must document his or her efforts to obtain the acknowledgment and the reason why it was not obtained.
- ▸ When first service delivery to an individual is provided over the Internet, through e-mail, or otherwise electronically, the provider must send an electronic notice automatically and contemporaneously in response to the individual's first request for service. The provider must make a good faith effort to obtain a return receipt or other transmission from the individual in response to receiving the notice.
- ▸ In an emergency treatment situation, provide the notice as soon as it is reasonably practicable to do so after the emergency situation has ended. In these situations, providers are not required to make a good faith effort to obtain a written acknowledgment from individuals.
- ▸ Make the latest notice (i.e., the one that reflects any changes in privacy policies) available at the provider's office or facility for individuals to request to take with them, and post it in a clear and prominent location at the facility.

- A covered entity may e-mail the notice to an individual if the individual agrees to receive an electronic notice.

See 45 CFR 164.520(c) for the specific requirements for providing the notice.

<u>Organizational Options.</u>

- Any covered entity, including a hybrid entity or an affiliated covered entity, may choose to develop more than one notice, such as when an entity performs different types of covered functions (i.e., the functions that make it a health plan, a health care provider, or a health care clearinghouse) and there are variations in its privacy practices among these covered functions. Covered entities are encouraged to provide individuals with the most specific notice possible.

- Covered entities that participate in an organized health care arrangement may choose to produce a single, joint notice if certain requirements are met. For example, the joint notice must describe the covered entities and the service

delivery sites to which it applies. If any one of the participating covered entities provides the joint notice to an individual, the notice distribution requirement with respect to that individual is met for all of the covered entities. See 45 CFR 164.520(d).

Frequently Asked Questions

To see Privacy Rule FAQs, click the desired link below:

FAQs on Notice of Privacy Practices

FAQs on ALL Privacy Rule Topics

(You can also go to http://answers.hhs.gov/cgi-bin/hhs.cfg/php/enduser/std_alp.php, then select "Privacy of Health Information/HIPAA" from the Category drop down list and click the Search button.)

ATTACHMENT C

Chart Review Policy

&

Procedure

QMP 10.00

MADERA COUNTY
BEHAVIORAL HEALTH SERVICES

POLICY NO.: QMP 10:00

SUBJECT: NETWORK PROVIDER QUALITY MANAGEMENT CHART REVIEW

POLICY:

At least annually, the Madera County Mental Health Plan (MHP) will review one chart and up to ten percent (10%) of all Madera County Medi-Cal beneficiary charts of each Network Provider.

PURPOSE:

To assure provision of high quality outpatient services through network providers.

PROCEDURE:

I. Each year the Managed Care Coordinator, or designee, will conduct an on site review of one to ten percent (10%) of the Madera County Mental Health Plan referral charts of each credentialed Network Provider.

II. The Network Provider will :

A. Provide access to all Madera County Medi-Cal beneficiary charts.

B. Assist in coordinating an area for the review.

C. Cooperate with the Managed Care Coordinator, or designee, and t he recommendations offered.

III. The Managed Care Coordinator, or designee, will:

A. Notify the Network Provider at least three weeks in advance of the scheduled review.

B. Assign a number to the reviewed chart and keep a list of names and numbers in a locked file in the MHP office.

C. Fill out the Network Provider Review Form.

D. Notify the Network Provider in writing of the commendations and recommendations of the Interagency Quality Improvement Committee (IQIC) within two weeks of the review.

E. Maintain strict confidentiality of information and chart:

1. No communication related to the review shall be discussed with persons outside Quality Management or the MHP.

2. Names of clients and treating providers shall not be used in minutes or reports.

3. Confidential information about clients, treatment providers, or reviewers shall not be disclosed or issued unless authorized by the local Behavioral Health Services Director or designee.

4. Violation of any of these ethical codes shall be dealt with appropriately.

5. Feedback on the review will be given to the IQIC.

IV. This policy and any subsequent revisions shall be approved by the Quality Management Committee (QMC).

Madera County Mental Health Plan
Quality Improvement Review

Provider:______________________________Chart#__________________Date:____________

Reason for Review: Annual ☐ 24 visits or more ☐ 12 visits in 6 months ☐

DIAGNOSIS/DIAGNOSTIC PROCEDURAL REVIEW ITEMS

	(NI=Needs Improvement)	COMMENTS/ACTION REQUIRED
1. Diagnosis supported by pertinent clinical symptomatology and/or behavior?	YES ☐ NI ☐ NO ☐	
2. Diagnosis made in accordance with DSM IV TR Mulitaxial system	YES ☐ NI ☐ NO ☐	
3. Major symptoms in documentation included in diagnosis?	YES ☐ NI ☐ NO ☐	

TREATMENT RELATED ISSUES

1. Treatment modality (psychotherapy, etc.) indicated and sufficient for this client?	YES ☐ NI ☐ NO ☐	
2. Does provider demonstrate adequate skills/knowledge to address special issues?	YES ☐ NI ☐ NO ☐	
3. Specific, observable/measurable objectives listed?	YES ☐ NI ☐ NO ☐	
4. Is Assessment in chart and adequate?	YES ☐ NI ☐ NO ☐	
5. Is Treatment Plan in chart and adequate?	YES ☐ NI ☐ NO ☐	
6. Objectives related to global goals/impairment?	YES ☐ NI ☐ NO ☐	
7. Is medication regimen		

listed, if prescribed?	YES ☐ NI ☐ NO ☐	
8. Is there evidence of collaboration/consultation with psychiatrist/physician prescribing meds?	YES ☐ NI ☐ NO ☐	
9. Are any identified cultural issues/barriers being addressed in treatment?	YES ☐ NI ☐ NO ☐	
10. Written consent for release of information is signed prior to any release of written records or verbal contact with others? Dates and times of contacts documented?	YES ☐ NI ☐ NO ☐	
11. Special status situations such as imminent risk of harm, suicidal ideation or other potential risks are identified, documented, and updated?	YES ☐ NI ☐ NO ☐	
12. AOD issues identified, addressed and coordinated?	YES ☐ NI ☐ NO ☐	

PROGRESS NOTES

1. Is there a progress note for each visit?	YES ☐ NI ☐ NO	
2. Do the progress notes reflect a. The process of treatment? b. The progress of lack of, in treatment?	YES ☐ NI ☐ NO	
3. Do the notes reflect use of community resources when indicated, and are	YES ☐ NI ☐ NO	

these adequate to the needs in the case?		
4. Chart documents dates of follow-up appointments or, if appropriate, a discharge plan?	YES ☐ NI ☐ NO	

MANAGED CARE:

1. Completion of Re-authorization adequate?	YES ☐ NI ☐ NO	
2. Was Re-authorization Request submitted prior to Screening "End Date" or prior to visits ending?	YES ☐ NI ☐ NO	
3. Progress toward previous treatment goals?	YES ☐ NI ☐ NO	
4. Justification for service extension?	YES ☐ NI ☐ NO	
5. Provider and client signatures?	YES ☐ NI ☐ NO	
6. Client's name or ID number on each page?	YES ☐ NI ☐ NO	
7. Signed copy of NPP in chart?	YES ☐ NI ☐ NO	

COMMENT(S)/SIGNATURES OF REVIEW COMMITTEE

IQIC Chairperson:

Other Members:

1.

2.

3.

4.

5.

Delivered to the Quality Management Coordinator, or designee, by the IQIC Chairperson on (date):

Written comments to Provider sent on (must be written within two weeks):

ATTACHMENT D

Clinical Chart Documentation

Authorization/Reathorization/Network Provider

MHP 20.00

MADERA COUNTY
MENTAL HEALTH PLAN
209 E. 7TH Street
P.O. BOX 1288
MADERA CA 93638
(559) 673-3508
(559) 675-7758

Date: ____

Provider Name: ____

Provider Address: ____

____

The Madera County Mental Health Plan has authorized you to provide the following services:

Client Name: ____

Client I.D. No.: ____

Authorized HCPC/CPT Codes: ____

No. of Sessions: ____

Auth. Start Date: ____

Auth. Expiration Date: ____

Please note that the Expiration Date is the last date on which this service authorization can be used. After this date, the authorization will be automatically cancelled, even if all authorized sessions have not been used.

All payments are subject to the member's continued Medi-Cal eligibility, Mental Health Plan policy and reimbursement schedules.

If additional care or visits are required, you must contact the Mental Health Plan at 1-888-275-9779 (toll free) or (559) 673-3508 in Madera City to arrange further authorized visits. We cannot reimburse services that have not been preauthorized.

If you have any questions, please call the Mental Health Plan at the above numbers.

Sincerely,

____
Managed Care Clinician

Madera County Behavioral Health Services
P. O. Box 1288 / Madera, CA 93639-1288
209 E. 7th Street, Madera, CA 93637
(559)673-3508
(559)675-7758 (fax)

Service Authorization Request
For Providers Only

Client's Name (Last, First, Middle)	DOB	Age	CIN or SSN
Provider			Phone Number
Address			Fax Number
Submitted to MHP			Date Submitted to MHP

☐ Initial Authorization for "Client Assessment" only

☐ Initial Authorization
(Required documents: "Client Assessment" and "Client Plan")

☐ Re-Authorization
(Submit "Client Assessment Update" and "Client Plan" consistent with authorizing MHP's frequency requirements)

☐ Annual Re-Authorization
(Submit "Client Assessment Update" and "Client Plan" consistent with MHP's frequency requirements)

(Please note: The MHP may request clarifying information/documentation to process your request for any of the above)

Mental Health Services Requested	Frequency of Service(s) (Indicate How many AND select the Frequency)	Total Minutes Requested	Start Date	End Date	MHP Authorization (Initial approved service)
Evaluation and Management (Office or Other Outpatient Facility)	____Per ☐Week ☐Month ☐Authorization				
Individual Psychotherapy	____Per ☐Week ☐Month ☐Authorization				
Group Psychotherapy	____Per ☐Week ☐Month ☐Authorization				
Family Psychotherapy	____Per ☐Week ☐Month ☐Authorization				
Other	____Per ☐Week ☐Month ☐Authorization				

Explain why this service level is necessary

Client Name: Record/Identification Number:

Madera County Behavioral Health Services
P. O. Box 1288 / Madera, CA 93639-1288
209 E. 7th Street, Madera, CA 93637
(559)673-3508
(559)675-7758 (fax)

CHILD/YOUTH CLIENT TREATMENT PLAN FORM PROVIDER

(MHP Use Only) Authorization #:________________________________		
Code	# Visits	Authorized Period
		From: To:
		From: To:
Signature:		Date:

Date of this Client Plan:

Client Name:________________________________DOB:____________________Age Today:______________

SSN; ____________________________**CIN:**__________________ **Chart/Identification Number**__________________

Other Coordinated Services/Agencies Involved (with contacts if known): ☐ **None Known**

1. Agency: ______________________________Contact: _______________Phone:_______________

2. Agency:______________________________Contact:________________Phone:_______________

3. Agency:______________________________Contact:________________Phone:_______________

Treatment Goals

Specific, observable and/or quantifiable goals (include the current baseline)	Modalities and Interventions	Within what time frame (Duration)

I participated in the development of this plan and was offered a copy

_______________________________ ____________ _______________________________ ____________
Child/Youth Signature* Date Caregiver Signature Date

_______________________________ ____________ ______________
Provider Signature License Date:

*Child/Youth refuses or is unavailable to sign, please explain the refusal or unavailability here:

Client Name: Record/Identification Number:

Madera County Behavioral Health Services
P. O. Box 1288 / Madera, CA 93639-1288
209 E. 7th Street, Madera, CA 93637
(559)673-3508
(559)675-7758 (fax)

Á ADULT CLIENT TREATMENT PLAN FORM PROVIDER

(MHP Use Only) Authorization #:_______________			
Code	# Visits	Authorized Period	
		From:	To:
		From:	To:
Signature:			Date:

Date of this Client Plan:

Client Name:________________ DOB:________________ Age Today:________________

SSN; ________________ **CIN:________________ Chart/Identification Number________________**

Other Coordinated Services/Agencies Involved (with contacts if known): ☐ **None Known**

1. Agency: ________________ Contact: ________________ Phone:________________

2. Agency:________________ Contact:________________ Phone:________________

3. Agency:________________ Contact:________________ Phone:________________

Treatment Goals

Specific, observable and/or quantifiable goals (include the current baseline)	Modalities and Interventions	Within what time frame (Duration)

I participated in the development of this plan and was offered a copy

________________________________ ________________
Client Signature Date

________________________ ____________ ____________
Provider Signature License Date:

*Client refuses or is unavailable to sign, please explain the refusal or unavailability here:

Madera County Behavioral Health Services
P. O. Box 1288 / Madera, CA 93639-1288
209 E. 7th Street, Madera, CA 93637
(559)673-3508
(559)675-7758 (fax)

ASSESSMENT/AUTHORIZATION FORM PROVIDER

(MHP Use Only) Authorization #:__________		
Code	# Visits	Authorized Period
		From: To:
		From: To:
Signature:		Date:

Name:______________________________ DOB______________
Last First Middle Month Day Year

Medi-Cal #:____________________ MHP CLIENT #: ________________

Ethnicity (How does the client identify):______________Preferred Language:__________

Language Spoken at Assessment:______________Interpreter Yes ☐ No ☐ Who?__________

Primary Caregiver:____________________Relationship:________________

Address:________________City:____________State:_____Zip:_________

Phone:________________

Primary Caregiver is the Legal Guardian? Yes ☐ No ☐ If No:

Legal Guardian:____________________Relationship:________________

Address:________________City:____________State:_____Zip:_________

Phone:________________

Parents: Same as caregiver/legal guardian above? Yes ☐ No ☐ If no:

Mother:________________________Phone:________________

Address (if known):____________________City:________State:_____Zip:_____

Father:________________________Phone:________________

Address (if known):____________________City:________State:_____Zip:_____

Siblings:

__________________ ☐ At Home ☐ Foster Placement ☐ Unknown/neither ☐ Other______

__________________ ☐ At Home ☐ Foster Placement ☐ Unknown/neither ☐ Other______

Client Name: Record/Identification Number:

Additional Siblings (include birth order if known)

____

____

STRENGTHS AND RESOURCES: Check and describe all known client strengths and resources in achieving Client Plan goals. Complete as appropriate.

Skills, Interests and Desires of Client:

☐ **Interpersonal:** ____

☐ **Creative:** ____

☐ **Academic:** ____

☐ **Athletic:** ____

☐ **Other:** ____

Family:

☐ **Availability:** ____

☐ **Involvement:** ____

☐ **Skills and Interests:** ____

☐ **Other:** ____

Community/Social Supports for Client/Family:

☐ **Positive Peer/Adult Relationships:** ____

☐ **School, Job or Volunteer Activities:** ____

Client Name: Record/Identification Number:

☐ **Access to Leisure Activities:** ____________________

☐ **Cultural Activities:** ____________________

☐ **Spiritual Activities:** ____________________

Other: ____________________

PRESENTING PROBLEM/SYMPTOMS: (As stated by client/guardian):

____

____

____

HISTORY OF PRESENTING PROBLEM: e.g.(Precipitating events/stressors, etc.)

____

____

____

____

PREVIOUS TREATMENT: (Please check all that apply):

☐ Outpatient Chemical Dependency ☐ Outpatient Psychotherapy ☐ Self-Help Group

☐ Inpatient Chemical Dependency ☐ Psychotropic Medication Management ☐ None

☐ Use of traditional or alternative healing practices (describe with results below

☐ Neurological Testing Date if known________ Examiner if known:________

☐ Psychological Testing Date if known________ Examiner if known________

Other____________________

If "yes" to any of the above, please give dates & place of service:

____

____

Previous crisis contact? ☐ Yes ☐ No If yes, number of crisis services without hospitalization in the past 6 months? ☐ 0 ☐ 1 ☐ 2 ☐ 3 or more

Previous psychiatric hospitalization? Number of psychiatric hospitalizations in past 6 months

☐ 0 ☐ 1 ☐ 2 or more

Client Name: Record/Identification Number:

Most recent date and hospital____

Comments: Include earliest symptoms, age of onset, other support/stressors at time of onset, family understanding of the problem, response to treatment, other potential contributing factors, relevant family history and **any family mental health illness history**.

____

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SYMPTOM CHECKLIST

Check the "Ever" box if symptom was ever present.
Also check the "6 months" box if symptom was present in the past 6 months.

Depression ☐None

Ever	6 Months		Ever	6 Months	
☐	☐	Depressed Mood	☐	☐	Suicidal Behavior
☐	☐	Tearful	☐	☐	Irritable, easily annoyed
☐	☐	Loss of interest of pleasure	☐	☐	Often feels angry
☐	☐	Isolative or withdrawn	☐	☐	Homicidal ideation
☐	☐	Hopeless and/or helpless	☐	☐	Over-reactive (quick to anger)
☐	☐	Fatigue	☐	☐	Excessively happy or silly
☐	☐	Worthlessness, shame or guilt	☐	☐	Labile (sudden mood shifts)
☐	☐	Bored	☐	☐	Distinct mood cycles
☐	☐	Thoughts of non-suicidal self-harm	☐	☐	Episodes of excess energy, insomnia, and euphoria or rage
☐	☐	Suicidal thoughts			

☐ ☐ Other:____

Anxiety ☐None

Ever	6 Months		Ever	6 Months	
☐	☐	Anxious mood	☐	☐	Avoids talk or reminders of trauma
☐	☐	Separation anxiety	☐	☐	Hyper-vigilance or excessive startle
☐	☐	Feels tense or stressed	☐	☐	Panic Attacks
☐	☐	Excessive worry	☐	☐	Agoraphobia
☐	☐	Fears or phobias	☐	☐	Dissociation
☐	☐	Intrusive memories	☐	☐	Obsessions or compulsions
☐	☐	Flashbacks (trauma re-experience)			

☐ ☐ Other:____

Client Name: Record/Identification Number:

Sleep, Appetite and Elimination ☐ None

Ever	6 Months		Ever	6 Months	
☐	☐	Initial insomnia	☐	☐	Poor Appetite
☐	☐	Middle insomnia	☐	☐	Rapid weight gain
☐	☐	Late insomnia	☐	☐	Weight loss (unintentional)
☐	☐	Sleeps excessively	☐	☐	Excessive weight loss (intentional)
☐	☐	Nighttime fears	☐	☐	Bed wetting
☐	☐	Frequent nightmares	☐	☐	Daytime enuresis
☐	☐	Night terrors	☐	☐	Encopresis
☐	☐	Excessive appetite			

☐ ☐ Other:____

Thought and Perception ☐ None

Ever	6 Months		Ever	6 Months	
☐	☐	Difficulty concentrating	☐	☐	Visual hallucinations
☐	☐	Auditory hallucinations	☐	☐	Other hallucinations
☐	☐	Delusions	☐	☐	Perceptual distortions other than hallucinations
☐	☐	Disorganized thought process			
☐	☐	Bizarre behavior	☐	☐	Irrational or odd but not delusional thoughts (e.g., of persecution)

☐ ☐ Other:____

Activity, Attention & Impulse ☐ None

Ever	6 Months		Ever	6 Months	
☐	☐	Overactive or fidgety	☐	☐	Difficulty completing tasks
☐	☐	Slowed or lethargic	☐	☐	Talks excessively
☐	☐	Short attention span	☐	☐	Impulsive (act without thinking)
☐	☐	Easily distracted			

☐ ☐ Other:____

Conduct ☐ None

Ever	6 Months		Ever	6 Months	
☐	☐	Defiant, uncooperative, oppositional	☐	☐	Threatens, bullies or intimidates
☐	☐	Frequent lying	☐	☐	Runaways
☐	☐	Blames others for own misbehavior	☐	☐	Cruel to animals
☐	☐	Controlling, bossy or manipulative	☐	☐	Truancy
☐	☐	Breaks rules	☐	☐	Breaking into car or building
☐	☐	Provokes	☐	☐	Stealing
☐	☐	Property destruction	☐	☐	Vandalism, tagging/graffiti
☐	☐	Physical aggression toward others	☐	☐	Gang involvement
☐	☐	Impulsive, reactive aggression	☐	☐	Fire-setting

☐ ☐ Other:____

Client Name: Record/Identification Number:

Attachment ☐ **None**

Ever	6 Months		Ever	6 Months	
☐	☐	Poor eye contact	☐	☐	Physically intrusive
☐	☐	Disinterest in relationships	☐	☐	Resistant to being touched
☐	☐	Difficulty making relationships	☐	☐	Overly attached to objects
☐	☐	Clingy			

☐ ☐ Other:____

Sexuality and Gender ☐ **None**

Ever	6 Months		Ever	6 Months	
☐	☐	Sexualized behavior	☐	☐	Gender preference conflict
☐	☐	Inappropriate or high-risk sexual beh.	☐	☐	Gender identity conflict
☐	☐	Forced sexual contact—Victim	☐	☐	Inappropriate sexual comments
☐	☐	Forced sexual contact—Perpetrator			
☐	☐	Forced sexual contact—Perpetrator			

☐ ☐ Other:____

Neuro-Cognitive ☐ **None**

Ever	6 Months		Ever	6 Months	
☐	☐	Low intellectual functioning	☐	☐	Motor delay
☐	☐	Learning disorder	☐	☐	Head injury
☐	☐	Speech or language delay/disorder			

☐ ☐ Other:____

Comment on the most prominent checked symptoms that need additional information:

____

____

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Client Name: Record/Identification Number:

Risk Assessment

Suicidality: ☐ None ☐Thoughts ☐Impulses ☐Plan ☐Means

☐Duration/Frequency____

Homicidality: ☐None ☐Thoughts ☐Impulses ☐Plan ☐Means

☐Duration/Frequency____

Describe:____

____

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____

Document special situations that present a risk to the child or others identified in the "Symptom Checklist".

____

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Client Name: Record/Identification Number:

Substance Use/Abuse
Answer the following questions about all current drug and alcohol use. List applicable drug(s) for items marked "yes"

Type of Substance	Prenatal Exposure	Age at First Use	Current Substance Use					
☐ Not Applicable (comments required)	None/ Unknown		None/ Denies	Current Use	Current Abuse	Current Dependence	In Recovery	Client-Perceived Problem
☐ Alcohol	☐		☐	☐	☐	☐	☐	☐Yes ☐No
☐ Amphetamines (Speed/Uppers, Crank, Ritalin)	☐		☐	☐	☐	☐	☐	☐Yes ☐No
☐ Cocaine/Crack	☐		☐	☐	☐	☐	☐	☐Yes ☐No
☐ Opiates (Heroin, Opium, Methadone)	☐		☐	☐	☐	☐	☐	☐Yes ☐No
☐ Hallucinogens (LSD, Mushrooms, Peyote, Ecstasy	☐		☐	☐	☐	☐	☐	☐Yes ☐No
☐ Sleeping Pills, Pain Killers, Valium or Similar	☐		☐	☐	☐	☐	☐	☐Yes ☐No
☐ PCP (Phencyclidine) or Designer Drugs (GHB)	☐		☐	☐	☐	☐	☐	☐Yes ☐No
☐ Inhalants (Paint, Gas, Glue, Aerosols)	☐		☐	☐	☐	☐	☐	☐Yes ☐No
☐ Marijuana/Hashish	☐		☐	☐	☐	☐	☐	☐Yes ☐No
☐ Methamphetamines	☐		☐	☐	☐	☐	☐	☐Yes ☐No
☐ Tobacco/Nicotine	☐		☐	☐	☐	☐	☐	☐Yes ☐No
☐ Caffeine (Energy Drinks, Sodas, Coffee, etc.)	☐		☐	☐	☐	☐	☐	☐Yes ☐No
☐ Over the Counter: specify in comments below	☐		☐	☐	☐	☐	☐	☐Yes ☐No
☐ Other Substance(s): specify in comments below	☐		☐	☐	☐	☐	☐	☐Yes ☐No

Does the client report receiving any alcohol and drug services:
☐ Yes, from this provider ☐Yes, from a different provider ☐No

Client Name: Record/Identification Number:

Comment on any co-occurring abuse/use as they relate to mental health symptoms and behaviors:

Mental Status Examination Note cultural and age factors for descriptors when applicable				
Appearance	☐ Older than stated ☐ Younger than stated ☐ Eccentric	☐ Meticulous, ☐ Appropriate grooming/dress for age/culture	☐ Seductive ☐ Unique features ☐ Poor hygiene	Describe:
Eye Contact	☐ Good	☐ Fair	☐ Poor	Describe:
Speech	☐ Normal for age/situation ☐ Soft ☐ Loud ☐ Overly talkative ☐ Brief responses	☐ Non-verbal ☐ Rapid ☐ Pressured ☐ Rambling ☐ Monotone	☐ Excessive Profanity ☐ Slurred ☐ Stammer/Stutter ☐ Vocal Tic ☐ Other speech difficulty	Describe:
Attitude	☐ Responsive ☐ Engaging ☐ Cooperative ☐ Uncooperative	☐ Superficial ☐ Guarded/distant ☐ Provocative/limit testing ☐ Manipulative/ deceitful	☐ Angry/hostile ☐ Shy/timid ☐ Dramatic ☐ Demanding/ Insistent	Describe:
				Describe:

Client Name: Record/Identification Number:

Behavior/ Motor Activity	☐Normal for age/situation ☐Slowed ☐Overactive/ restless	☐Impulsive ☐Agitated ☐Unusual mannerism	☐Tremor ☐Other involuntary movement	
Mood	☐Happy ☐Sad	☐Irritable or Angry ☐Bored	☐Anxious ☐Fearful	Describe:
Affect	☐Euthymic (normal/ appropriate) ☐Sad ☐Tearful ☐Overly happy ☐Irritable	☐Angry ☐Silly ☐Anxious ☐Fearful ☐Bored	☐Labile (rapidly shifting) ☐Flat, blunted, constricted ☐Incongruent with topic or thoughts	Describe:
Perceptions	☐Normal	☐Hallucinations ☐Auditory ☐Visual ☐Other	☐Other perceptual distortion	Describe:
Delusions	☐None	☐Persecutory	☐Grandiose	Describe:
Thought Form/ Process	☐Linear and rational ☐Racing	☐Disorganized or loose	☐Pervasive	Describe:

Thought Content	☐Normal ☐Delusions ☐Obsessions	☐Excessive preoccupation ☐Other involuntary movement	☐Unusual, non-delusional ideations (suspicious, etc.)	Describe:
Thoughts of Harming Self or Others	☐None ☐Suicidal ideation ☐Suicidal intent	☐Thoughts or intent of non-lethal self-injury	☐Unusual, non-delusional ideations (suspicious, etc.)	Describe:
Sensorium	Oriented to: ☐Person ☐Place ☐Time ☐Situation Memory intact for: ☐Immediate ☐Recent ☐Remote	Alertness: ☐Alert ☐Clouded/ confused ☐Other Attention: ☐Good ☐Fair ☐Poor	Intellectual functioning: ☐Average or higher ☐Below average Insight/Judgment ☐Good ☐Fair ☐Poor	Describe:

Cultural Factors
Explain how the client's cultural factors, including those previously described, impact current functioning and the treatment plan. Include immigration, acculturation, sexual orientation, and other significant factors in your explanation.

Client Name: Record/Identification Number:

Social Factors
Explain how the client's social factors, including those previously described, impact current functioning and the treatment plan. Include living situation, daily activities and other significant factors in your explanation.
Functional Impairment Assess the Impact of the client's impairment in the following areas
Home:
School:
Community:
Work:
Family Relationships:

Client Name: Record/Identification Number:

Peer Relationships:
Is there significant impairment in an important area of life functioning? ☐ Yes ☐No
Probability of significant deterioration in an important area of life functioning? ☐Yes ☐No
(Child only) Has a mental disorder which can be corrected or ameliorated? ☐Yes ☐No

Developmental Status			
Categories	Within Normal Limits	Unknown	Concerns/Issues (describe the specific concern or issue)
Parental Risk Factors: i.e., mental health issues, substance/physical abuse	☐	☐	
Cognitive Functioning: i.e., Developmental delay, learning disability, making academic progress	☐	☐	
Sensory Functioning: i.e., Visual or auditory deficits, other sensory deficits	☐	☐	
Fine and Gross Motor Skills: i.e., Motor deficits, delay in acquiring skills	☐	☐	
Early Childhood: i.e., Prenatal care, delivery complications, neglect or abuse, separation anxiety	☐	☐	

Middle Childhood: i.e., Problems with peers and/or siblings, age appropriate behavior, problems at school	☐	☐	
Adolescence: i.e., Sexual/gender issues, truancy, illegal behavior, substance/alcohol use (including nicotine)	☐	☐	
Other:			

Current Medications
If known, include drug names, dosages, when prescribed and who prescribed them. Document any experienced side effects and/or compliance issues
Current medications, including psychiatric, if known:
Past medications, including psychiatric ,if known:
Supplements/Vitamins:

Client Name: Record/Identification Number:

Medical History			
Current Primary Medical Care Provider: Address: Phone:			
Date of Last Physical Exam:		☐Unknown	☐No—Explain below
Date of Last Dental Exam:		☐Unknown	☐No—Explain below
Are there any health concerns (medical illness, medical symptoms?	☐Unknown/ None Reported	☐No	☐Yes—Explain below
Non-Medication Allergies (food, pollen, bee sting, etc?	☐Unknown/ None Reported	☐No	☐Yes—Explain below
Medication Allergies (list type)	☐Unknown/ None Reported	☐No	☐Yes—Explain below

Has the child or caregiver reported any of the following problems/experiences? (check all that apply)

☐ Asthma	☐Heart Problems	☐Surgery of any kind. Explain Below
☐Broken Bones	☐ High or Low Blood Pressure	☐Thyroid Problem
☐Convulsions or Seizure	☐Immune System Problems	☐Tuberculosis (TB)
☐Diabetes	☐Liver Problems or Hepatitis	☐Obesity
☐Exposure to Toxic Lead Levels	☐Motor or Movement Problems	☐Weight Gain or Loss, Explain Below
☐ Respiratory Problems	☐Urinary Tract or Kidney Problems	☐Eating Disorder
☐Cancer	☐Serious Rash or Other Skin Problems	☐Appetite Changes
☐ Head Injury	☐Pregnancy	☐Speech or Language Problems. Explain Below
☐ Hearing Problems	☐ Miscarriage	Vision Problems
☐ Sexually Transmitted Disease (STD)	☐Enuresis	☐Encopresis
☐Other		

Client Name: Record/Identification Number:

Comments:
Additional clarifying formulation information as needed. Please document any additional comments or information.

Client Name: Record/Identification Number:

<u>DSM-IV CODE AND DIAGNOSIS</u>:

	Code	Diagnosis	Primary Diagnosis	Secondary Diagnosis
Axis I	______________	____	[ ]	[ ]
	______________	____	[ ]	[ ]
Axis II	______________	____	[ ]	[ ]
	______________	____	[ ]	[ ]
Axis III	____			
Axis IV	____			
Axis V	_____________			

Current GAF:

Diagnosing

LPHA:______________________________Lic/Reg:____________________Date:_____________

LPHA Printed
Name:____Date:______________

LPHA Signature:____LIc/Reg:__________

Notice of Privacy Practices Offered to Client/Primary Caregiver? ☐Yes ☐No

Revised: 02-06-13

Madera County Behavioral Health Services
P. O. Box 1288 / Madera, CA 93639-1288
209 E. 7th Street, Madera, CA 93637
(559)673-3508
(559)675-7758 (fax)

ASSESSMENT UPDATE/AUTHORIZATION FORM PROVIDER

(MHP Use Only) Authorization #:________________________________

Code	# Visits	Authorized Period	
		From:	To:
		From:	To:
Signature:			Date:

Date of this Assessment Update:

Client Name:________________________________DOB:____________________Age Today:____________

SSN; ____________________________CIN:__________________ Chart/Identification Number__________________

Please describe any changes to the following areas since the most recent Client Assessment dated:

Primary Caregiver:____________________________Relationship:__________________Phone:______________

Address:____________________________________City:____________________State:________Zip__________

Resources (Interests, family, community, school and peers, etc. ☐ No Change

Presenting Problems: ☐ No Change

Symptoms (mood, anxiety, thought, perception, attention, sexuality, gender, etc): ☐ No Change

Substance Abuse: ☐ No Change

Mental Status Exam: ☐ No Change

Relevant Physical Health Conditions: ☐ No Change

Cultural Factors: ☐ No Change

Social Factors: ☐ No Change

Developmental Status: ☐ No Change

Medications: ☐ No Change

Coordinated Services/Agencies: ☐ No Change

Functional Impairment (home, school/education, community, work, family/peers relationships): ☐ No Change

1. Significant Impairment in an important area of life functioning? ☐ Yes ☐ No
   If yes, describe in space below

2. Probability of significant deterioration in an important area of life functioning? ☐ Yes ☐ No

3. (Child Only) Has a mental disorder which can be corrected or ameliorated? ☐ Yes ☐ No

Diagnosis ☐ No Change

I:

II:

III:

IV:

V: GAF: Past Year: Current Year:

Additional Comments (Optional):

LPHA Printed Name: Date:

LPHA Signature: Lic:

MADERA COUNTY BEHAVIORAL HEALTH SERVICES

MENTAL HEALTH DISCHARGE SUMMARY

Presenting problem (description of why client is seeking services now: include impact/impairment on social, work and/or academic functioning, current stressors and/or precipitaing events):

Treatment or services provided:

If other, specify

Response to service provided:

- O Worse
- O Unchanged
- O Minimal Improvement
- O Moderate Improvement
- O Marked Improvement
- O Unknown

List any other medications not included above:

Reason for discharge

Additional comments relating to the above:

Date of discharge

Signature of Staff Completing Form:

Name: Date: Time: O Yes ⊙ No

Signature of Staff Entering Information (If Different from Above):

Name: Date: Time: O Yes ⊙ No O N/A

Form WIZ46MH; Version 2.00; 6/24/10

MADERA COUNTY BEHAVIORAL HEALTH SERVICES
MENTAL HEALTH CLIENT TRANSFER

Transfer from   Transfer to

Reason for transfer:

Other relevant information:

Signature of Staff Completing Form:

Name: Date: Time: O Yes ⊙ No

Signature of Staff Receiving Transfer:

Name: Date: Time: O Yes ⊙ No

Signature of Staff Entering Information (If Different from Above):

Name: Date: Time: O Yes ⊙ No O N/A

Form WIZ45MH; 2.00; 6/24/10

MADERA COUNTY
BEHAVIORAL HEALTH SERVICES

POLICY NO.: MHP 20:00

SUBJECT: NETWORK PROVIDER CHART REVIEW AND ONGOING MONITORING SYSTEM

POLICY:

Any client that has had 24 visits with a network provider will have their chart reviewed.

PURPOSE:

To assure provision of appropriate utilization of outpatient services through network providers.

PROCEDURE:

A. Any client that has had over 24 visits or more with a network provider will be reviewed. At such time, an MHP clinician will conduct an on site review of such charts of each credentialed Network Provider.

B. The Network Provider will :

1. Provide access to all Madera County Medi-Cal beneficiary charts.
2. Assist in coordinating an area for the review.
3. Cooperate with the MHP clinician, or designee, and the recommendations offered.

C. The MHP clinician or designee, will:

1. Notify the Network Provider at least three weeks in advance of the scheduled review.
2. Fill out the Network Provider Review Form.
3. Notify the Network Provider in writing of the recommendations of the reviewer.
4. Maintain strict confidentiality of information and chart:
   a. No communication related to the review shall be discussed with persons outside Quality Management or the MHP.
   b. Names of clients and treating providers shall not be used in minutes or reports.
   c. Confidential information about clients, treatment providers, or reviewers shall not be disclosed or issued unless authorized by the local Behavioral Health Services Director or designee.

d. Violation of any of these ethical codes by the MHP Clinician or designee shall be dealt with appropriately.

5. A need for a correction during a review will require a Plan of Correction within 30 days from the date of the notification letter from MHP.

Note: See Also Quality Management policy QMP 10:00 Network Provider Chart Review

ATTACHMENT E

Mental Health Plan

Billing Forms

MHP 32.00

MADERA COUNTY
BEHAVIORAL HEALTH SERVICES

POLICY NO.: MHP 32:00

SUBJECT: NETWORK PROVIDER BILLING

POLICY:

Network providers shall be paid promptly for authorized services to Medi-Cal beneficiaries.

PURPOSE:

To insure that billings for mental health services are submitted, verified and paid in a timely manner.

PROCEDURE:

A. The network provider may submit billing forms to the Madera County Mental Health Plan (MHP) for all Madera County beneficiaries who received pre-authorized services during the previous calendar month.

 1. A separate form is required for each beneficiary served.

B. Payment requests for outpatient services shall be made using a MHP claim form (attached) or HCFA 1500.

C. Payment requests for inpatient services will be made on UB 92 (attached).

D. Billing forms shall be sent to:

 Madera County Mental Health Plan

 P. O. Box 1288

 Madera, CA 93639-1288

E. Claims must be submitted within thirty (30) days of the close of the month when services were provided.

F. Payment will be authorized for valid claims for outpatient mental health services if:

 1. Services were pre-authorized by the Mental Health Plan.

 2. Services were delivered by a contract provider and were in accordance with contract agreements.

 3. Beneficiary was eligible for Medi-Cal reimbursement when services were provided.

G. The following will apply when Medi-Cal is the payer of last resort:

 1. Share of Cost

  a. Depending on a beneficiary's monthly income, Medi-Cal may require that the

individual/family meet a share of cost before Medi-Cal will reimburse for covered, authorized services. The provider must bill the beneficiary for any unmet share of cost before requesting payment from the Mental Health Plan (MHP).

b. When submitting a Medi-Cal claim for a beneficiary with a Share of Cost, the provider must attach copies of receipts indicating the individual has met the share of cost requirement for the month of services in claim. If the provider is collecting the share of cost from the beneficiary, the provider should complete a receipt for the money received.

   i. The receipt should include the following: Provider name and title, client and /or guardian name, client birth date, amount received, applicable dates of service.

2. Third Party Insurance

   a. When a beneficiary has private health insurance in addition to Medi-Cal, the following applies:

      i. The provider must bill the third party payer before requesting payment from MHP,

      ii. Within thirty (30) days of receipt, the provider must attach a copy of the third party payer denial letter or Explanation of Benefits (EOB) indicating the amount reimbursed by the third party payer,

      iii. MHP will only reimburse the difference of the approved network provider service rates and the payment amount received from the primary payer less any remaining share of cost. The total reimbursement from all payers shall not exceed the MHP service rate. The provider does not need preauthorization from MHP.

H. Reimbursement rates are included in provider contracts.

I. Payment will be mailed to providers within twenty (20) working days of receipt and verification of valid claims.

APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

1

2

3 PATIENT CONTROL NO.

4 TYPE OF BILL

5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM THROUGH | 7 COV D. | 8 N-C D. | 9 C-I D. | 10 L-R D. | 11

12 PATIENT NAME | 13 PATIENT ADDRESS

14 BIRTHDATE | 15 SEX | 16 MS | ADMISSION 17 DATE 18 HR 19 TYPE 20 SRC | 21 D HR | 22 STAT | 23 MEDICAL RECORD NO. | CONDITION CODES 24 25 26 27 28 29 30 | 31

32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE CODE DATE | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37 A B C

a b

38

39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

a b c d

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23

50 PAYER | 51 PROVIDER NO. | 52 REL INFO | 53 ASG BEN | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56

A B C

57 **DUE FROM PATIENT ▶**

58 INSURED'S NAME | 59 P. REL | 60 CERT. - SSN - HIC. - ID NO. | 61 GROUP NAME | 62 INSURANCE GROUP NO.

A B C

63 TREATMENT AUTHORIZATION CODES | 64 ESC | 65 EMPLOYER NAME | 66 EMPLOYER LOCATION

A B C

67 PRIN. DIAG. CD. | OTHER DIAG. CODES 68 CODE 69 CODE 70 CODE 71 CODE 72 CODE 73 CODE 74 CODE 75 CODE | 76 ADM. DIAG. CD. | 77 E-CODE | 78

79 P.C. | 80 PRINCIPAL PROCEDURE CODE DATE | 81 OTHER PROCEDURE CODE DATE A | OTHER PROCEDURE CODE DATE B | 82 ATTENDING PHYS. ID

OTHER PROCEDURE CODE DATE C | OTHER PROCEDURE CODE DATE D | OTHER PROCEDURE CODE DATE E

83 OTHER PHYS. ID A a b

OTHER PHYS. ID B a b

84 REMARKS a b c d

85 PROVIDER REPRESENTATIVE X | 86 DATE

UB-92 HCFA-1450

OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA — PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ____________ DATE ____________

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ____________

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. ___ . ___ 3. ___ . ___

2. ___ . ___ 4. ___ . ___

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

MADERA COUNTY MENTAL HEALTH PLAN

Billing Form

Provider Number:

MHP Client ID#: Authorization #

You may use this form for up to twelve authorized services.

Billable Services:

Date of Service (mm/dd/yy)	HCPC/CPT Code	Time	Rate Billed	Share of Cost Received	Primary Insurance Pmt	MHP USE ONLY
0T		In Minutes	$0.00	$0.00	$0.00	
0T		In Minutes	$0.00	$0.00	$0.00	
0T		In Minutes	$0.00	$0.00	$0.00	
0T		In Minutes	$0.00	$0.00	$0.00	
0T		In Minutes	$0.00	$0.00	$0.00	
0T		In Minutes	$0.00	$0.00	$0.00	
0T		In Minutes	$0.00	$0.00	$0.00	
0T		In Minutes	$0.00	$0.00	$0.00	
0T		In Minutes	$0.00	$0.00	$0.00	
0T		In Minutes	$0.00	$0.00	$0.00	
0T		In Minutes	$0.00	$0.00	$0.00	
0T		In Minutes	$0.00	$0.00	$0.00	
					TOTAL DUE	

Provider Information:

Name:

Mailing Address:

Phone #: ( ) -

Fax #: ( ) -

I attest that the above claim is true and correct; that no part has been previously paid; and that the amount is justly due. I understand that claims must be submitted within thirty (30) days after the close of the month when services were provided.

0T

Signature of Claimant

Diagnosis for Medi-Cal billing
assign a number between 1-4
Diagnosis #1 ________
Diagnosis #2 ________
Diagnosis #3 ________
Diagnosis #4 ________

PROVIDER Name
Provider Address
Provider City / State / Zip
Provider Phone Number
MHP Invoice for Specialty Mental Health Services

Period
May-14
month of service

Client Nar invoice 1

Client ID client 1

Service Date	HCPC	Time in Minutes	Rate	Share of Cost Received	Primary Insurance Pmt	Dx # 1-4	Mins	Min/Hour Conversion	Charges	MHP USE ONLY
								0:00	$0.00	
								0:00	$0.00	
								0:00	$0.00	
								0:00	$0.00	
								0:00	$0.00	
								0:00	$0.00	
								0:00	$0.00	
								0:00	$0.00	
								0:00	$0.00	
								0:00	$0.00	
								0:00	$0.00	
								0:00	$0.00	
								0:00	$0.00	
								0:00	$0.00	
								0:00	$0.00	
								0:00	$0.00	
								0:00	$0.00	
								0:00	$0.00	
							0		$0.00	

Certification: I certify, to the best of my knowledge and belief, under penalty of perjury, that the claim submission identified above is true, accurate and complete. I understand that payment of this claim file will be from Federal and/or State funds, and that any falsification, or concealment of material facts, may be prosecuted under Federal and/or State laws.

Signature ______________________ Date ______________

Title ______________________

ATTACHMENT F

Provider Complaint & Appeal Process

MHP 34.00

MADERA COUNTY
BEHAVIORAL HEALTH SERVICES

POLICY NO.: **MHP 34:00**

SUBJECT: **PROVIDER COMPLAINT AND APPEAL PROCESS**

POLICY:

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 complaint concerns a denied or modified request for a Mental Health Plan (MHP) payment authorization or the processing or payment of a provider's claim to MHP.

PURPOSE:

To define and inform providers of the process to register a complaint and appeal a denial or modification for payment.

PROCEDURE:

Good provider relations are essential to the effective delivery of mental health services. The following describes the process by which providers may address their complaints and appeals to the Madera County MHP for resolution.

I. Definitions

   A. Services: inpatient or outpatient Medi-Cal mental health services.

   B. Complaint: a statement registered by a provider regarding a problem that can be resolved informally.

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

   D. Provider: a mental health provider who has a contract with MHP to provide services to Medi-Cal beneficiaries.

   E. Mental Health Plan (MHP): responsible for the administration of Medi-Cal mental health services in Madera County.

II. Informal Complaint Process

   A. Provider complaints may address one or more of the following:

      1. Lack or level of payment for an authorized or emergency claim.

      2. Delay of payments

      3. Lack of information or cooperation by MHP staff.

4. Disagreement by the provider with utilization review decisions made by MHP staff.

5. A dispute with MHP regarding interpretations of provider action which are reasons for contract terminations.

6. Other issues as determined by the provider.

B. A provider may present a complaint to the Managed Care Coordinator by telephone, in person or in writing.

1. The Managed Care Coordinator will attempt to resolve the complaint. Suggested solutions will be provided to the complainant within two weeks from receipt of the complaint.

2. If the provider is not satisfied with the response, the provider may file an appeal under the circumstances listed in section III. below.

III. Appeals: Formal Problem Resolution Process

A provider has the right to access the provider appeal process at any time before, during or after the provider problem resolution process has begun, when the complaint concerns a denied or modified request for MHP payment authorization or the processing or payment of a providers claim to MHP.

A. Denial of Authorization for Services

1. A provider may file a written appeal concerning the denial for authorization of specialty mental health services directly to the Behavioral Health Services Director, or designee.

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

3. The appeal shall be reviewed and a decision made by the Behavioral Health Services Director, or designee, and other qualified staff as assigned by the Behavioral Health Services Director, or designee.

a. MHP shall use personnel not involved in the initial decision to respond to the provider's appeal.

4. The Behavioral Health Services Director, or designee, will have thirty (30) days from the post mark or fax date of receipt of the appeal to complete an evaluation of the appeal.

5. 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.

6. This formal process may also be utilized by any residential treatment program provider. MHP will respond within 48 hours of

receipt of all required materials.

B. Denial of Claim Payments

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

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

3. The written appeal shall be submitted to the Behavioral Health Services Director, or designee, within thirty (30) calendar days of the postmark date of the notification of denial or delay of claim payments.

4. The Behavioral Health Services Director, or designee, shall have ten (10) working days from the post mark or fax date of receipt of the appeal to complete an evaluation of the appeal.

5. The appeal shall be reviewed and a decision made by the Behavioral Health Services Director, or designee, and other qualified staff as assigned by the Behavioral Health Services Director, or designee. Personnel not involved in the initial denial decision will be used to respond to the provider's appeal.

6. The provider will be notified in writing if the appeal is upheld, if there is a proposed resolution (i.e., partial payment) or no basis is found for altering the original decision.

7. If the provider appeal is upheld or partial payment is approved, the Behavioral Health Services Director, or designee, will have fifteen (15) working days to process the claim for payment to the provider.

8. The Behavioral Health Services Director, or designee, shall maintain a log of all MHP Formal Problem Resolution Requests and decisions, including disposition of the problems, which shall be submitted monthly to the County Mental Health Quality Improvement Committee.

9. The Formal Problem Resolution Log information shall include a method for identifying the provider, date of receipt, nature of the problem, time period allowed for resolution, party responsible for addressing the problem, date for resolution or disposition of the problem.

a. These records will be open to review by the State Department of Mental Health, State Department of Health Services and the Federal oversight agency.

b. The Log shall document the resolution of the problem within 30 calendar days of its receipt, or the reason why it could not be resolved.

10. The formal problem resolution process may be utilized by any residential treatment program provider. MHP will respond within 48 hours of receipt of all required materials.

11. MHP may file an appeal concerning the processing or payment of its claim for services paid through the Short-Doyle/Medi-Cal system to the Department of Mental Health.

C. The contact person for all beneficiary and provider problems and appeals is:

Mental Health Plan Supervisor

Madera County Behavioral Health Services

P. O. Box 1288

Madera, CA 93639-1288

(559) 675-7850; FAX (559) 675-7758

ATTACHMENT G

Reporting Unusual Occurrences

QMP 12.00

MADERA COUNTY
BEHAVIORAL HEALTH SERVICES

POLICY NO.: QMP 12:00

SUBJECT: REPORTING UNUSUAL OCCURRENCES

AUTHORITY:

Section 784.15, Unusual Occurrences, California Code of Regulations; Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statues of 1994: Sections 5675 and 5768 Welfare and Institutions Code.

POLICY:

Madera County Behavioral Health Services (BHS) shall notify the State Department of Mental Health (DMH) of all unusual occurrences as soon as possible after becoming aware of the event. Unusual occurrences are defined as epidemic outbreaks, poisonings, fires, major accidents, death from unnatural causes or other catastrophes and events that jeopardize the welfare, safety or health of clients, staff, and/or members of the community.

PURPOSE:

To provide a mechanism for immediate notification to the DMH in compliance with State regulations.

PROCEDURE:

A. Staff or network providers who witness any incident or unusual occurrence are required to verbally report the event as soon as possible to the BHS Director and submit a written report within one working day.

B. The BHS Director, or designee, will provide notification to DMH via telephone or email within 24 hours of becoming aware of the occurrence.

C. The BHS Director, or designee, will send a report by certified U.S. mail to DMH within five (5) calendar days of notification of the unusual occurrence.

D. The written report will include the following:

  1. Description of the event, including outcome.
  2. Staff/Provider's investigation and conclusions about the event.
  3. A list of persons directly involved or who have direct knowledge of the event.
  4. The report will be sent to:

     Chief Medi-Cal Oversight, Southern Region
     State Department of Mental Health
     P.O. Box 59063
     Norwalk, CA 90652

E. DMH retains the right to independently investigate unusual occurrences and to expect the cooperation of Staff/Providers.

BEHAVIORAL HEALTH SERVICES

REPORT OF UNUSUAL OCCURRENCE/INCIDENT

1. INCIDENT DATE:	2. INCIDENT TIME:
3. PERSON(S) INVOLVED IN INCIDENT:	
4. ADDRESS OR LOCATION OF INCIDENT:	
5. PERSON REPORTING INCIDENT:	
6. TYPE OF INCIDENT:	
7. WITNESS(ES):	
8. INCIDENT DESCRIPTION (Be as specific as possible. Include names, addresses, times, dates, injuries, damages):	
9. PLANNED FOLLOW-UP:	
-- 10. Signature	Date
11. SUPERVISOR'S SIGNATURE -- Signature	Date

REVIEWED BY QUALITY MANAGEMENT COORDINATOR____________________________ DATE _________________

REVIEWED BY DIRECTOR ____ DATE _________________

ATTACHMENT H

Consumer

Death/Suicide

QMP 13.00

MADERA COUNTY
BEHAVIORAL HEALTH SERVICES

POLICY NO.: QMP 13:00

SUBJECT: CONSUMER DEATH/SUICIDE

POLICY:

Behavioral Health Services Administration will be notified immediately when a death of a consumer or recent consumer occurs.

PURPOSE:

To assure timely notification of Behavioral Health Services Administration of any consumer death no matter what the cause of death.

PROCEDURE:

I. Notification of Behavioral Health Services Director.

A. When staff members of the Madera County Behavioral Health Services become aware of a death of a consumer, they will notify their immediate supervisor who will telephone the Behavioral Health Services Director or designee. In the case of a Network Provider consumer's death, the Network Provider will call the Director or designee.

B. The facts related to the death will be documented and sent to the Director within 24 hours. The report will include, as applicable:

1. Name.
2. Birth date.
3. Pertinent information related to the death and events surrounding the death.
4. Plans for outreach efforts with family or friends of the decedent, including consumer peers.
5. Plans/identified concerns related to preventing other occurrences, e.g., "copycat" suicides.
6. Plans for debriefing with involved staff and description of other unmet needs.

C. The Director, or designee, will notify the Medical Records Supervisor, or designee, who will immediately seal the decedent's medical record by placing it in a manila envelope, sealed with tape and marked "Sealed Record - Access limited to Behavioral Health Services Director or designee."

1. Access to the sealed chart will be given to only the Behavioral Health

Services Director or designee.

2. No additional information will be placed in the chart after it is sealed.

3. Any additional relevant information may be placed in separate confidential envelope and put in manila envelope with chart by Medical Records Supervisor.

II. Psychological Autopsy

A. As soon as the Coroner's Report is received, if death is deemed a suicide or homicide, a psychological autopsy will be scheduled with the Interagency Quality Improvement Committee (see QMP 11:00).

ATTACHMENT I

Provider Satisfaction Survey

MADERA COUNTY MENTAL HEALTH PLAN PROVIDER SATISFACTION SURVEY

Please check the appropriate box based on your experience with Madera County Mental Health Plan.

Question/Comments	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Applicable
1. My invoices are processed in a timely manner.	☐	☐	☐	☐	☐
Comments: .					
2. I am satisfied with the paperwork that is required by MHP.	☐	☐	☐	☐	☐
Comments: .					
3. I am satisfied with the authorization process.	☐	☐	☐	☐	☐
Comments: .					
4. I receive helpful, appropriate feedback from the MHP and Quality Management regarding site and chart reviews.	☐	☐	☐	☐	☐
Comments: .					
5. If I have a problem, I know whom to contact.	☐	☐	☐	☐	☐
Comments: .					
6. I am satisfied with the Madera County MHP's utilization management system.	☐	☐	☐	☐	☐
Comments: .					
7. Referrals from the MHP are appropriate for my setting.	☐	☐	☐	☐	☐
Comments: .					
Other Comments: .					

ATTACHMENT J

Consumer

Satisfaction

Survey

QMP 24.00

MADERA COUNTY

BEHAVIORAL HEALTH SERVICES

POLICY NO.: **QMP 24:00**

SUBJECT: **CONSUMER SATISFACTION SURVEYS**

POLICY:

Madera County Behavioral Health Services (BHS) will seek continuous improvement of mental health services provided to Madera County residents and Medi-Cal beneficiaries.

PURPOSE:

To develop a way to receive feedback from consumers regarding services they received.

PROCEDURE:

A. The Performance Outcome & Quality Improvement Survey (POQI) will be administered to outpatient consumers, as required by the State Department of Mental Health (DMH), following instructions provided by DMH.

1. The Quality Management Coordinator, or designee, will coordinate the administration of the POQI with the program manager/supervisor at each site.

2. When results are released by DMH, a written summary and oral presentation will be provided to outpatient consumer providers and the Madera County Mental Health Board. The Mental Health Board will review the summary and provide written comment to the California Mental Health Planning Council.

B. Survey forms for hospitalized beneficiaries and Network Provider consumers will be developed by Quality Management Committee members with input from consumers.

1. Any client or Quality Management Committee member may make suggestions regarding the content of the form.

2. The Quality Management Committee will approve a final version of the survey form.

3. Prior to discharge, a survey and self-addressed return envelope will be offered to beneficiaries admitted to a hospital by a BHS Hospital Liaison, or designee.

   a. Surveys received from hospital patients will be returned to and date stamped upon receipt by the Quality Management Coordinator, or designee.

b. The Quality Management Coordinator, or designee, will compile returned surveys on a quarterly basis and report results to the Interagency Quality Improvement Committee (IQIC).

c. The Quality Management Coordinator, or designee, will inform the applicable hospitals of the results of the surveys.

4. Annually, the Quality Management Administrative Assistant, or designee, will mail Consumer Satisfaction surveys directly to Network Provider consumers, along with a stamped, self-addressed return envelope.

a. All Network Providers will give a survey to clients at the end of their sessions. Surveys should be completed outside the office setting and returned in the self-addressed, stamped envelope.

b. All Network Provider Consumer Surveys will be returned to the Quality Management Coordinator, or designee, for compilation and summary.

c. The Quality Management Coordinator, or designee, will inform Network Providers of the results of the survey.

d. The Quality Management Coordinator, or designee, will report results to the IQIC.

C. Surveys requesting demographic data, such as, ethnicity, gender and age will be culturally sensitive, including questions about culture, language and lifestyle.

D. Surveys will be in all threshold languages.

E. Survey statistics will be shared with the appropriate Quality Improvement Committee.

F. Survey information will be summarized for the Quality Management Committee.

G. Original surveys will be kept in a locked file in the office of the Quality Management Coordinator, or designee.

H. When surveys contain comments in the nature of a grievance, consumers will be contacted to determine if they wish to file a grievance. This will occur only if the consumer indicates on the survey that permission to contact is granted and provides enough optional identifying information.

I. Any trends noted through surveys will be reported to the appropriate Quality Improvement Committee for program recommendation.

1. Program recommendations will be made to appropriate program managers/supervisors.

J. Summaries of the surveys will be forwarded to the Quality Management Committee for approval.

ATTACHMENT K

Site Certification Form

for Mental Health

as of 8-8 -2013

SITE CERTIFICATION

As of 08.08.13 this is the most current document.

For possible updates please see the link:

http://www.dhcs.ca.gov/services/MH/Documents/Cert_Re-Cert%20PROTOCOL_(ver.%2007_03_2012)_Updated_8-8-2013_(PDF_view).pdf

Or Call MHP at (559) 673-3508

ATTACHMENT L

Quality Management

Committee

QMP 8

MADERA COUNTY
BEHAVIORAL HEALTH SERVICES

POLICY NO.: **QMP 08:00**

SUBJECT: **QUALITY MANAGEMENT COMMITTEE**

POLICY:

The Director of Madera County Behavioral Health Services (BHS) will appoint a Quality Management Committee to oversee the Quality Improvement Activities of the Mental Health Plan (MHP).

PURPOSE:

To develop procedures for structuring the Quality Management Committee that will be responsive to the needs of consumers and providers and assure that MHP provides quality services.

PROCEDURE:

A. The BHS Director will appoint members of the Quality Management Committee, consisting of:

1. Quality Management Committee Chair (Department Director or designee)
2. Quality Management Committee Co-Chair (designated to act as Chair in Director's/designee's absence, may be a member listed below)
3. Division Managers
4. Medical Director, or designee
5. Quality Management Coordinator
6. Mental Health Plan Supervisor
7. Clinical Staff Representative(s)
8. Clerical Staff Representative(s)
9. Compliance Officer/Data Manager, or designee
10. Patient's Rights Advocate
11. Client/Family Representatives
12. Network Provider Representatives

B. The Quality Management Committee members will reflect the ethnic and geographic diversity of the County whenever possible.

C. The Quality Management Committee activities include:

a. When a telephone call is received regarding a mental health emergency, the PA or OA will inform the caller that his/her call is being transferred immediately to Crisis Services.

- If the PA or OA is unable to transfer the call due to the caller's mental state, he/she will immediately notify clinical staff to talk to the caller and complete the transfer to the Crisis Services staff or inform the caller to go to the emergency room at Madera Community Hospital.

b. When an individual walks into a BHS clinic, and appears to be in a crisis situation, the PA or OA will immediately notify a member of Crisis Services and s/he will complete an S&D form.

3. When a client is seen in an off-site after/hours crisis situation, the following procedure will be observed:

a. The crisis team will turn in the S&D to the Admissions PA or OA the next morning or within one (1) business day.

b. The Admissions PA or OA will check Anasazi and Admissions to find out if a client with crisis/after hours S&D is currently open in the system.

c. The crisis services staff will complete the Brief Assessment or the Crisis Assessment in Anasazi.

d. If the crisis staff determines that a screened individual is ineligible for services, the Crisis Worker will open and close the client in Anasazi. The crisis worker will determine if a NOA-A is needed. If a NOA-A is necessary, the crisis worker will complete and dispense the original to the client and a copy to MHP and Medical Records. The MHP clinician will log the S&D.

e. All S&D's will be approved for 60 days including ones marked O/C (Open/Close).

4. For all MCBHS off site S&D's please refer to MHP 15:00, Off-Site Screening and Dispositions.

5. Non-English Telephone Calls

a. If the caller is Spanish-speaking only and the PA or OA is non Spanish-speaking, he/she will transfer the incoming call to a designated Spanish-speaking staff as indicated in the procedures for the use of Spanish-speaking interpreters.

b. If the caller has other language needs, or the Spanish-speaking interpreter is not available, the PA or OA will utilize the Language Line (aka AT&T Language Line) or transfer the call to a MHP Clinician, who will access the Language Line to complete the call. (See MHP 12:00; MHP 14:00).

6. Non-Mental Health Calls

a. When a call is received from an individual requesting non-mental health information and/or information regarding other services, the PA or OA will provide the information when appropriate. If the PA or OA does not have the requested information or is in doubt regarding the nature of the call, he/she will refer the call to a MHP Clinician. Requests for clinical information will always be forwarded to the MHP clinician.

B. Triage

The MHP Clinician will gather appropriate clinical information in order to determine the type of referral required to meet the needs of the individual requesting mental health services. The MHP Clinician will review the information obtained by the PA or OA and conduct a triage screening utilizing the MHP Screening and Disposition form. Based on the information obtained by the PA or OA and the individual's presenting problem, mental health history and funding source, the MHP Clinician will refer the individual to the most appropriate provider.

1. Medi-Cal Beneficiaries

   a. If it appears the individual's condition can best be treated by physical health care, the MHP Clinician will refer the individual to their health care provider, e.g., Anthem Blue Cross or CalVIVA Health/Health Net.

      - If the individual does not have a primary care physician, he/she will be given the 800 numbers of Anthem Blue Cross or CalVIVA Health/Health Net.
      - The individual will be asked to call MHP if physical health care does not address his/her needs.

   b. Medi-Cal beneficiaries will be referred for a mental health assessment if specialty mental health services are indicated, based on the symptoms described.

      - Referrals will be made to the appropriate Madera County Behavioral Health Services (BHS) clinic/clinician.

   c. The MHP Clinician will complete a Screening and Disposition form for each child meeting eligibility criteria when a parent/guardian requests mental health services for more than one child in the family.

2. Non-Medi-Cal Beneficiaries

   a. If it appears the individual's condition can best be treated by physical health care, the MHP Clinician will refer the individual to an appropriate physical health care provider.

      - If the individual does not have a primary care physician, he/she will be given the names and telephone numbers of at least three primary care physicians and/or clinics.
      - The individual will be asked to call MHP if physical health care does not address his/her needs.

b. Non-Medi-Cal beneficiaries will be referred for a mental health assessment if mental health services are indicated, based on the symptoms described that meet the Target Population criteria. (See 1E.)

- Referrals will be made to an Almond Access Center Clinician.
- The MHP Clinician shall complete a S&D for each child meeting eligibility criteria when a parent/guardian requests mental health for more than one child in the family.

C. Referral for Mental Health Services

1. When the MHP determines the individual needs more intensive on-going therapy/services, s/he shall refer the client to the appropriate clinic/service or provider.

a. When making a referral, the MHP Clinician shall consider the individual's needs and/or requests, including age, culture, language, gender and ethnic group.

- When indicated, the MHP Clinician may contact providers to ascertain their expertise with different cultures, problem areas, language and ethnicity.

b. The MHP Clinician shall provide information, as needed, in response to any questions or concerns the individual may have related to his/her identified problem and assistance needs.

c. The MHP Clinician will seek to match the level of intervention specific to the individual's needs.

d. Beneficiaries who do not meet Target Population who have Medi-Cal or a primary care physician.

- They will be referred to their Medi-Cal provider or to their primary care physician stating they do not meet medical necessity criteria.
- Person may also attend the short-term DBT group for up to 20 group services.

e. Individuals who meet the Target Population.

- The MHP Clinician may refer the individual to Madera County BHS Centers or a Madera County Mental Health Program when an adult or child presents with symptoms that meet the Target Population (symptoms and impairments related to the following DSM-IV TR Diagnosis: Psychotic Disorder (D/O), Bipolar D/O, Major Depressive D/O, Debilitating Anxiety D/O's).

(a) Indicators such as poor independent functioning, lack of ability to maintain employment, need for psychotropic medication, past psychiatric hospitalizations and other high indicators of need for

comprehensive services would also result in a referral to Madera County BHS Centers.

- Thirty (30) days of service are authorized at this time.

D. Scheduling

1. During regular business hours, the MHP Clinician will inform the caller of the process for scheduling an assessment.

    a. If the caller is referred to a Provider, the caller will be given two (2) referrals and asked to call the MHP (after choosing a therapist) for final authorization. If the caller would prefer, the MHP Clinician can contact Network Providers in the caller's area to find out availability.

    b. If the caller is referred to the main clinic in Madera, the Family Treatment Center and/or AOD, the caller will be advised of the assessment schedule.

    c. If the caller is referred to the Chowchilla Center, the caller will be asked to call the Chowchilla Center to schedule an appointment.

    d. If the caller is referred to the Oakhurst Counseling Center, the caller will be asked to call the Oakhurst Counseling Center to schedule an appointment.

2. If a parent/legal guardian has requested services for more than one child, the MHP Clinician will inform the parent/legal guardian of the assessment schedule, and request that they only bring in one child at a time per assessment day.

Madera County Behavioral Health Services
SCREENING AND DISPOSITION

Time: ______________________ Staff ID: ______________________
Interpreter: ☐ Yes ☐ No
Comments: ______________________

INSURANCE INFORMATION

Insurance: ______________________
Medi-Cal CIN#: ______________ Medicare #: ______________
If Medi-Cal: ☐ Anthem Blue Cross ☐ CalVIVA
County Code: ______________ Aid Code: ______________
Physician/Clinic: ______________________

CLINICAL INFORMATION

Presenting Problem:

☐ Acute Crisis
☐ Medication
☐ Family/Marital Issues
☐ Depression
☐ Chronic Psych. Disorder
☐ Anxiety
☐ School Problems
☐ IEP
☐ Domestic Violence
☐ Court Ordered
☐ Child Abuse/Molest
☐ Other

Comments on symptoms: .

History of outpatient treatment: ☐ Yes ☐ No ☐ Unknown
Comments: .

History of inpatient treatment ☐ Yes ☐ No ☐ Unknown
Comments: .

Family history of mental illness: ☐ Yes ☐ No ☐ Unknown
Comments: .

Previous/current diagnosis: ☐ Yes ☐ No ☐ Unknown
Comments: .

Previous/current psychotropic meds: ☐ Yes ☐ No ☐ Unknown
Comments: .

SUBSTANCE USE HISTORY

Current problems due to alcohol/drug use: ☐ Yes ☐ No ☐ Unknown
Comments: .

History of alcohol/drug/medication abuse: ☐ Yes ☐ No ☐ Unknown
Comments: .

Prior treatment for substance abuse: ☐ Yes ☐ No ☐ Unknown
Comments: .

Tobacco products: ☐ Yes ☐ No ☐ Unknown
Comments: .

Caffeine products: ☐ Yes ☐ No ☐ Unknown
Comments: .

CULTURAL ISSUES

Are issues present which impact selection of a provider? ☐ Yes ☐ No ☐ Unknown

If yes, describe:

☐ Gender ☐ Language Spoken ☐ Age

☐ Race/Ethnicity ☐ Religious/Spiritual ☐ Sexual Orientation

☐ Other

Comments: .

Has individual expressed preference for provider? ☐ Yes ☐ No

If yes, Provider: .

Does individual/guardian desire interpreter for primary language? ☐ Yes ☐ No

Language: .

Does individual/guardian need assistance with reading? ☐ Yes ☐ No

If yes, type: ☐ Large Print ☐ Oral presentation ☐ Explanation

RECOMMENDED SERVICES

Clinic:

☐ Almond Access Center ☐ Oakhurst Counseling Center ☐ Chowchilla Counseling Center

☐ Family Treatment Center

Services:

☐ Psychiatric Emergency Services ☐ Medication Evaluation ☐ Assessment/Treatment

☐ Network Provider ☐ Other

If other, please list: ☐ AOD ☐ MAP

Other programs: .

NETWORK PROVIDER AUTHORIZATION
(This section to be COMPLETED BY MHP STAFF ONLY)

Authorization #: .

Network Provider: .

Number of Visits: . HCPC Codes: .

Start Date: . End Date: .

Care Staff: . Date: .

Extension: . Reason: .

Signature of Staff Obtaining Information: .

Signature of Interpreter: .

Clinical: .

ATTACHMENT M

Interagency Quality

Committee

MADERA COUNTY
BEHAVIORAL HEALTH SERVICES

POLICY NO.: **QMP 09:00**

SUBJECT: **INTERAGENCY QUALITY IMPROVEMENT COMMITTEE**

POLICY:

The goal of the Madera County Mental Health Plan (MHP) is the continuous improvement of mental health services provided to Madera County residents and Medi-Cal beneficiaries. Cultural competence is considered fundamental to quality services and must be embedded in all quality improvement initiatives.

PURPOSE:

To develop procedures for structuring Interagency Quality Improvement Committee (IQIC) activities that will assure that the Mental Health Plan provides quality services in inpatient and Network Provider settings.

PROCEDURE:

I. The Behavioral Health Services Interagency Quality Improvement Committee shall be comprised of the following individuals appointed by the Behavioral Health Services Director:

   A. Quality Management Coordinator, or designee
   B. Adult Services Representative
   C. Children's Services Representative
   D. Supervising Clinician
   E. MHP Clinician
   F. Psychiatrist
   G. Hospital Liaison
   H. Staff Clinician
   I. MHP Administrative Assistant

II. IQIC activities shall include:

   A. Review and evaluate Inpatient and Network Provider: Consumer Satisfaction Surveys, Consumer Grievances, Appeals, and Suggestions.
   B. Review inpatient charts, retrospectively, that meet one or more of the following quality indicators:

1. Length of stay one day or less.
2. Length of stay 14 days or more.
3. Three or more admissions within six months.
4. Readmitted in 30 days or less.
5. Quality of care concerns.

C. Discuss the review of at least one chart or up to ten percent (10%) of all Madera County beneficiary charts of each Network Provider annually (See Policy QMP 10:00).

D. Review all County homicides and suicides, maintaining statistics on demographics (See Policy QMP 11:00).

E. Review and discuss any matter referred to IQIC by the Behavioral Health Services Director and make recommendations.

III. The Interagency Quality Improvement Committee will meet monthly.

IV. Confidentiality will be maintained in all IQIC matters.

V. Dated and signed minutes of all Interagency Quality Improvement Committee meetings will be maintained.

ATTACHMENT N

GUIDES/INFORMATIONAL BROCHURES/FORMS

Consumer/Beneficiary Rights &
Problem Solving Resolution Guide.

Formal Grievance

Services Guide

CONSUMER RIGHTS

Madera County mental health consumers are entitled to:

- Respectful treatment with consideration for privacy by all Behavioral Health Services staff.
- Service provided in a safe environment.
- Receive information on treatment options.
- Request and receive a copy of medical records and request corrections.
- Participate in decisions regarding heath care including the right to refuse treatment.
- Request a change in the level of care, change of provider, and a second opinion regarding any treatment issue.
- Be free from restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

Mental Health Plan	**(559) 673-3508**
Toll free	**(888) 275-9779**
Patients' Rights Advocate	**(559) 673-3508**
Toll free	**(888) 275-9779**
State Ombudsman	**(800) 896-4042**
TTY	**(800) 735-2929**
Relay Services (English/Spanish)	**711**
Speech to Speech	**(866) 288-1909**

Behavioral Health Director

Dennis Koch, MPA
(559) 673-3508
Toll free (888) 275-9779
TTY (800) 735-2929

S/MHP/QMC/Forms - Problem Resolution Guide–salmon. Rvsd:10-20-09, 6-11-12, 9-6-12, 12-10-13

CONSUMER RIGHTS AND PROBLEM RESOLUTION GUIDE

MADERA COUNTY BEHAVIORAL HEALTH SERVICES

GRIEVANCES

When a mental health consumer has a problem or grievance regarding mental health services, we encourage him/her to discuss those concerns with their therapist or program staff. They may also talk to the Quality Management Coordinator at (559) 673-3508 or (888) 275-9779; or call the Patients' Rights Advocate at (559) 673-3508, or the California Department of Mental Health Ombudsman at (800) 896-4042, or TTY (800) 735-2929.

If you are unable to resolve a concern about any aspect of service, you may at any time, for any reason file a grievance with the Quality Management Coordinator. A grievance may be filed verbally by calling (559) 673-3508 or (888) 275-9779, or by completing a Grievance Form. Formal Grievance forms and pre-addressed envelopes are available in the reception area of all clinics and provider offices. The completed Grievance Form may be given to a Consumer Representative, mailed in the envelope provided, or mailed to the following address:

Madera County
Behavioral Health Services
Mental Health Plan
P.O. Box 1288
Madera, CA 93639-1288

The Quality Management Coordinator will notify you within five working days that your grievance has been received. A written response notifying you of the final resolution will be sent within sixty calendar days.

You may designate someone to act on your behalf at any time. A consumer representative is also available to assist you by calling (559) 673-3508 or (888) 275-9779.

The Patients' Rights Advocate may be contacted at (559) 673-3508 to assist in resolving grievances.

APPEALS

If you wish to appeal an "Action" by the Mental Health Plan, you may call the Quality Management Coordinator at (559) 673-3508 or (888) 275-9779 – toll free. An "Action" is when the MHP:

- Denies or limits authorization of a requested service.
- Reduces, suspends, or terminates a previously authorized service.
- Denies, in whole or in part, payment for a service.
- Fails to act within the timeframes for disposition of Standard Grievances, the resolution of Standard Appeals, or the resolution of Expedited Appeals.
- Fails to provide services in a timely manner, as determined by the MHP.

An Expedited Appeal may be used when a decision must be made quickly to protect the beneficiary's life, health, or ability to function at a maximum level

Beneficiaries may request a State Fair Hearing after the Appeal process has been completed. You may contact the Patients' Rights Advocate or the State Ombudsman listed below to assist in filing for a State Fair Hearing. All State Fair Hearing decisions are final.

YOUR MENTAL HEALTH SERVICES WILL NOT BE AFFECTED IN ANY WAY BY FILING A GRIEVANCE OR APPEAL, OR REQUESTING A STATE FAIR HEARING.

SUGGESTIONS

Consumer suggestions are important in providing quality, effective services. Providers have (green) Suggestion Forms in service areas. Consumer suggestions are welcome and can be placed in designated boxes or given directly to a staff member or Patients' Rights Advocate.

DERECHOS DEL CONSUMIDOR

Consumidores de salud mental del Condado de Madera tienen derecho de:

- Ser tratados con respeto por todo el personal de salud mental.
- Recibir servicio en un ambiente seguro.
- Recibir información o opciones de tratamiento.
- Solicitar y recibir una copia de expedientes médicos y solicitar correcciones.
- Participar en decisiones con respecto a cuidado médico incluyendo el derecho de rechazar el tratamiento.
- Pedir un cambio en el nivel del cuidado, un cambio del proveedor, y una segunda opinión con respecto a cualquier problema del tratamiento.
- Derecho a estar libre del alojamiento o del aislamiento usado como los medios de la coerción, de la disciplina, de la conveniencia, o de la venganza.

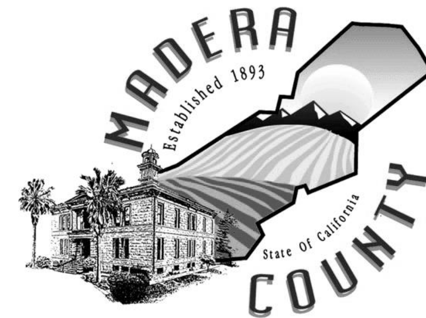
Plan De Salud Mental	**(559) 673-3508**
Llamada Gratis	**(888) 275-9779**
Partidario de Derechos al Paciente	**(559) 673-3508**
	(888) 275-9779
Mediador Estatal	**(800) 896-4042**
TTY	**(800) 855-3000**
Servicios de Relevo	**Marque 711**
Voz a Voz	**(866) 288-4151**

Director de Salud Mental

Dennis Koch, MPA
(559) 673-3508
Llamada Gratis (888) 275-9779
TTY (800) 855-3000

S/MHP/QMC/Forms Resolution Guide – salmon–Spn. Rvsd: 10-20-10, 6-11-12, 9-6-12, 12-10-13

DERECHOS DE CONSUMIDOR Y GUÍA DE RESOLUCIÓN DE PROBLEMAS



SERVICIOS MÉDICOS DEL COMPORTAMIENTO DEL CONDADO DE MADERA

QUEJAS

Cuando un consumidor de los servicios de salud mental tiene un problema o una queja acerca de los servicios de salud mental, lo animamos que hable sobre sus preocupaciones con su terapista o el personal del programa. También pueden platicar con el Terapista del Manejo de Calidad al (559) 673-3508 o (888) 275-9779 o llame al Partidario de Derechos del Paciente al (559) 673-3508 o al Mediador de California del Departamento de Salud Mental al (800) 896-4042 o TTY (800) 855-3000.

Si no es capaz de resolver su preocupación sobre cualquier aspecto del servicio, usted puede a cualquier tiempo, por cualquiera razón someter una queja al Terapista del Manejo de Calidad. Puede someter una queja verbal al llamar al (559) 673-3508 o (888)275-9779 o al llenar una Forma de Queja Formal. Formas de Queja Formal y sobres dirigidos son disponibles en la área de recepción en todas las clínicas y oficinas del proveedor. Las formas completas de Queja Formal pueden entregarse al Representante del Consumidor, mandarlas por correo en el sobre dirigido y estampillado o mande por correo al la siguiente dirección:

Madera County
Behavioral Health Services
Managed Care Coordinator
P.O. Box 1288
Madera, CA 93639-1288

El Terapista del Manejo de le dará notificación que su queja fue recibida dentro de 5 días. Una respuesta escrita que le notifica de la resolución final será enviada dentro de sesenta días de calendario.

Puede designar a alguien que actué en su nombre a cualquier tiempo. Un representante de consumidores también esta disponible para asistirle al llamar al (559) 673-3508 o (888) 275-9779.

El Abogado de Los Derechos del Paciente puede ser llamado al (559) 673-3508 para asistirle en resolver los agravios.

SUPLICAS

So usted desea suplicar una "Acción" por el Plan de Salud Mental, puede llamar al Terapista del Manejo de Calidad al (559) 673-3508 o (888) 275-9779 – llamada gratis. Una "Acción" es cuando el Plan de Salud Mental:

- Le niega o limita la autorización de un servicio solicitado.
- Reduce, suspende, o termina un servicio previamente autorizado.
- Niega, en entero o en parte, pago por un servicio.
- Falla de proporcionar servicios de una manera oportuna, según lo determinado por el Plan de Salud Mental.
- Falla de actuar dentro de la marca del tiempo para la disposición de agravios estándares, la resolución de suplicas estándares, o la resolución de suplicas apresuradas.

Una suplica apresurada puede ser utilizada cuando una decisión se debe tomar rápidamente para proteger la vida, salud, o la capacidad de funcionar de un nivel máximo de los beneficiarios.

Beneficiarios tienen el derecho de solicitar una audiencia Justa del Estado después que el proceso de Apelación ha sido completado. Usted puede ponerse en contacto con el Abogado de los Derechos del Paciente o al Mediador del Estado enumerado abajo para asistirle a archivar una Audiencia Justa del Estado. Todas las decisiones de la Audiencia Justa del Estado son finales.

SUS SERVICIOS DE SALUD MENTAL NO SERÁN AFECTADOS DE NINGUNA MANERA AL SOMETER UNA QUEJA, SUPLICA, O UNA AUDIENCIA JUSTA DEL ESTADO.

SUGESTIONES

Sugestiones y opiniones son una parte importante al proveer cuidado de calidad e efectivos. Proveedores tienen Formas de Sugestiones en áreas de servicios. Sugestiones de consumidores son bienvenidos y pueden ser puestas en las cajas designadas o entregarlas directamente al miembro personal o al Partidor de Derechos de Pacientes.

If you need assistance with completing this form:

- You may ask any Mental Health Plan (MHP) staff to assist you.
- You may ask for the Consumer Services Representative at (559) 673-3508.
- You may call the Patient's Rights Advocate at (559) 673-3508.
- You may ask anyone to act on your behalf at any time.

Please return this completed form to the receptionist or place in the Suggestion Box or mail in the self-addressed envelope to:

Madera County Behavioral Health Services
Mental Health Plan
P.O. Box 1288
Madera, CA 93639

Quality Management Coordinator
(559) 673-3508
(888) 275-9779

Patients' Rights Advocate
(559) 673-3508
(888) 275-9779

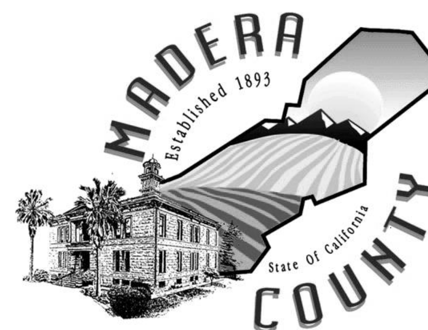
State Ombudsman
(800) 896-4042

Behavioral Health Director
Dennis Koch, MPA
(559) 673-3508
Toll free (888) 275-9779

TTY (800) 735-2929
Cal Relay Dial 711
Speech to Speech (866) 288-1909

S/MHP/QMC/Forms/Grievance-blue Rvsd10-20-09, 9-6-12, 12-10.13

FORMAL GRIEVANCE



MADERA COUNTY BEHAVIORAL HEALTH SERVICES

MADERA COUNTY BEHAVIORAL HEALTH SERVICES

FORMAL GRIEVANCE

NOTE: Your current Madera County Behavioral Health Services will **NOT** be adversely affected in any way by filing a grievance. If you have a Formal Grievance, please complete this form and place it in the addressed envelope provided; seal, stamp, and mail. You may designate someone to act on your behalf. You will be kept informed of the status of your grievance.

Please print or write clearly.

Date: ____________ Service Location: ____________________

Consumer Name: ______________________ Birth Date: __________

Name of Legal Guardian if on behalf of a Minor: ____________________

Address: ________________________________

May we send mail to you at this address? *Yes* ☐ or *No* ☐

Telephone Number (Please indicate best time to call): ____________________

May we call you at this telephone number? *Yes* ☐ or *No* ☐

May we leave a message for you at this telephone number? *Yes* ☐ or *No* ☐

1. **Describe the reason(s) for requesting a <u>Formal Grievance</u>. Please be specific by including names, dates, and times whenever possible:**

Name: ______________________ Date(s) of Incident: ______________

Describe Grievance: ________________________________

____

____

____

2. Have you tried to resolve the problem(s) before requesting the Formal Grievance?

   Yes ☐ Please describe what you have done to try to resolve the problem and include the results.

   ____

   ____

   ____

   No ☐ I have not made any prior attempts to resolve the grievance.

3. What would you like to see happen to resolve this grievance?

   ____

   ____

   ____

I understand that the Mental Health Plan staff will be authorized to contact any involved provider in order to resolve my Grievance. The Mental Health Plan staff will also be authorized to discuss any and all information that shall be needed to evaluate and resolve this Grievance.

______________________ ______________________________

Today's Date Signature of person making request

FOR COUNTY USE ONLY

REVIEWED BY: ______________________ **DATE:** ______________

RECOMMENDATIONS: ______________________________

____

____

Si necesita asistencia para completar esta forma:

- Usted puede pedir asistencia a cualquier personal del Plan de Salud Mental.
- Usted puede preguntar por el Representante De Servicios De Consumidores al (559) 673-3508.
- Usted puede llamar al Partidario De Derechos Para Pacientes al (559) 673-3508o (888) 275-9779.
- Usted puede delegar a cualquier persona que le represente a cualquier tiempo.

Por favor de devolver esta forma completada a la recepcionista o ponga en la caja de sugestiones o mande por correo en el sobre dirigido y estampillado a:

Servicios Médicos del Comportamiento del Condado de Madera
Plan de Salud Mental
P.O. Box 1288
Madera, CA 93639

Manejador de Servicios de Salud
(559) 673-3508
(888) 275-9779

Partidario de Derechos Para Pacientes
(559) 673-3508
(888) 275-9779

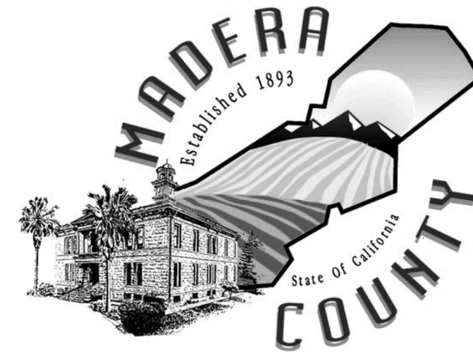
Mediador Estatal
(800) 896-4042

Mental Health Director
Dennis Koch, MPA
(559) 673-3508
Toll free (888) 275-9779

TTY (800) 735-2929
Servicios de Relevo Marque 711
Voz a Voz (866) 288-4151

S/MHP/QMC/Forms/Grievance-blue-Spn. Revised: 10-20-09, 9-6-12, 12-10-13

QUEJA FORMAL



SERVICIOS MÉDICOS DEL COMPORTAMIENTO DEL CONDADO DE MADERA

SERVICIOS MÉDICOS DEL COMPORTAMIENTO DEL CONDADO DE MADERA

QUEJA FORMAL

NOTA: Al completar esta queja, sus Servicios De Salud Mental Del Condado De Madera no serán adversamente afectados. Si usted tiene una Queja Formal, por favor complete esta forma, ponga en el sobre dirigido y estampillado y envié por correo. Usted puede delegar a una persona que le represente en una queja. Usted estará informado sobre el estado de su queja.

Por favor escriba claramente.

Fecha: ____________ Lugar del Servicio: ____________

Nombre del Consumidor: ____________ Fecha de Nacimiento: ____________

Nombre del Guardián Legal si es por parte de un Menor: ____________

Dirección: ____________

¿Nos permite enviar correo a esta dirección? *Si* ☐ o *No* ☐

Número de Teléfono (Por favor indique el mejor tiempo para llama): ____________

¿Nos permite llamarle a este número de teléfono? *Si* ☐ o *No* ☐

¿Nos permite dejar un mensaje para usted en este número de teléfono? *Si* ☐ o *No* ☐

1. **Describa la razón(es) por su solicitud de la Queja Formal. Por favor sea específico en incluyendo nombres, fechas y horas en cuanto le sea posible:**

Nombre:: ____________ Fecha(s) del Incidente: ____________

Describa su Queja: ____________

____

____

2. ¿Ha tratado de resolver el problema(s) antes de pedir la Queja Formal?

   Si ☐ Por favor describa lo que ha hecho para resolver el problema e incluya los resultados.

____

____

____

   No ☐ No he hecho atentados previos para resolver la queja.

3. ¿Que es lo que le gustaría ver que pasara para resolver esta queja?

____

____

____

Yo entiendo que los empleados de Servicios de Salud Y Comportamiento (BHS) estarán autorizados de ponerse en contacto con cualquier proveedor de servicios involucrado en orden de resolver mi Queja. Los empleados de Servicios de Salud Y Comportamiento también estarán autorizados de discutir cualquier y toda información que pueda ser necesitada para evaluar y resolver esta Queja.

____________ ____________

Fecha de Hoy Firma de la Persona Haciendo Esta Solicitud

PARA EL USO DEL CONDADO SOLAMENTE

REVIEWED BY: ____________ **DATE:** ____________

RECOMMENDATIONS: ____________

____

____

GRIEVANCE PROCEDURE

We encourage you to discuss concerns about mental health services with your therapist or program staff. You may also talk to the Quality Management Coordinator at (559) 673-3508 or (888) 275-9779; or call the Patients' Rights Advocate at (559) 673-3508 or (888) 275-9779; or the California Department of Mental Health Ombudsman at (800) 896-4042; or TTY (800) 735-2922.

If you are unable to resolve a concern about any aspect of service, you may at any time, for any reason file a grievance with the Quality Management Coordinator. A grievance may be filed verbally by calling (559) 673-3508 or (888) 275-9779, or by completing a Grievance Form. Formal Grievance forms and pre-addressed envelopes are available in the reception area of all clinics and provider offices.

You may designate someone to act on your behalf at any time. A consumer representative is also available to assist you by calling (559) 673-3508 or (888) 275-9779.

The Patients' Rights Advocate may be contacted at (559) 673-3508 to assist in resolving grievances.

APPEAL PROCEDURE

If you wish to appeal an "Action" by the Mental Health Plan, you may call the Quality Management Coordinator at (559) 673-3508 or (888) 275-9779 – toll free. An "Action" is when the MHP:

- Denies or limits authorization of a requested service.
- Reduces, suspends, or terminates a previously authorized service.
- Denies, in whole or in part, payment for a service.
- Fails to act within the timeframes for disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals.
- Fails to provide services in a timely manner, as determined by the MHP.

An Expedited Appeal may be used when a decision must be made quickly to protect the beneficiary's life, health, or ability to function at a maximum level

Beneficiaries have a right to request a State Fair Hearing after the Appeal process has been completed. You may contact the Patient's Rights Advocate or the State Ombudsman listed below to assist in filing for a State Fair Hearing. All State Fair Hearing decisions are final.

YOUR MENTAL HEALTH SERVICES WILL NOT BE AFFECTED IN ANY WAY, NOR WILL YOU BE SUBJECT TO ANY PENALTY, BY FILING A GRIEVANCE OR AN APPEAL.

Brochures/BHS Services Guide – ltr – yellow
Rev: 10-20-09, 6-11-12, 8-27-12, 07-21-13, 07.30.14

MADERA COUNTY BEHAVIORAL HEALTH SERVICES

SERVICES GUIDE

P. O. Box 1288 / Madera, CA 93639-1288
209 E. 7th St. / Madera, CA 93638

24-HOUR PHONE LINES

Emergency Psychiatric Services
Madera County (559) 673-3508 Toll Free (888) 275-9779

Screening and Referral for Services
Madera County (559) 675-7850 Toll Free (888) 275-9779

WHERE TO GET MENTAL HEALTH SERVICES

Behavioral Health Services (BHS)
209 E. 7th Street, Madera (559) 673-3508

Chowchilla Recovery Center (CRC)
215 S. 4th St., Chowchilla, CA (559) 665-2947

Oakhurst Counseling Center (OCC)
49774 Road 426, #D, Oakhurst (559) 683-4809

BHS, CRC and OCC are open for beneficiaries with scheduled appointments and emergency walk-ins 8:00 a.m. to 5:00 p.m., Monday through Friday.

If you speak a different language or have physical limitations, we will help you find available, appropriate, and accessible services.

WELCOME
RESIDENTS OF MADERA COUNTY

A variety of mental health services and programs are available to mental health clients in Madera County. Madera County Behavioral Health Services provides a continuum of services to children, youth, adults, and their families at three locations as well as with contracted private therapists in the community. A list of mental health providers is available upon request.

SCREENING AND REFERRAL

Services may be accessed by calling the Mental Health Plan (MHP) at the number listed below. Callers will speak to a licensed mental health clinician who will provide a referral to the most appropriate programs and/or services.

Madera County (559) 675-7850
Toll free (888) 275-9779

CHILDREN'S SERVICES

- Assessment is a thorough analysis of the history and current status of an individual's mental, emotional, and behavioral concerns. Cultural issues and history are also identified. The assessment is used to determine what mental health services are needed.
- Individual, family, and group counseling/therapy are provided to persons who would benefit.
- Psychiatric services evaluate and monitor individuals who need and are willing to take psychotropic medication.
- Dual Diagnosis groups are available for adolescents who have both a mental health and substance related diagnosis.
- Case Management services are offered to help families and individuals connect with community resources.
- Therapeutic Behavioral Services (TBS) are available for children/ youth up to age 21 who are full scope Medi-Cal beneficiaries. TBS is one-on-one therapeutic contact between a mental health provider and a beneficiary for a specified brief time period designed to maintain the child's or youth's residential placement and prevent psychiatric hospitalization by resolving target behaviors and achieving short-term goals.
- There is a collaborative program between Madera County Behavioral Health Services, Madera County Department of Social Services, Madera County Public Health Department, and Madera County Office of Education. The program offers assessment and comprehensive treatment for children in out-of-home placement.
- Juvenile Justice programs provide individual, group, and family counseling for youth who are court ordered through the Probation Department or referred by the School Attendance Review Board.

ADULT SERVICES

- Assessment is a thorough analysis of the history and current status of the individual's mental, emotional, and behavioral concerns. Pertinent cultural issues and history are also identified. The assessment is used to determine what mental health services are needed.
- Individual, family, and group counseling/therapy are provided to persons who would benefit.
- Case management helps consumers find and connect with resources to solve and alleviate everyday living problems.
- Intensive case management helps individuals stabilize and improve their ability to function and prevent possible hospitalization.
- Psychiatric services evaluate and monitor individuals who need and are willing to take psychotropic medication.
- Dual Diagnosis treatment is provided for individuals who have both a mental health and a substance related diagnosis.
- Intensive treatment and prevention services are also available through the Mental Health Services Act funding. These include peer/family member support services available though Hope House in Madera and the Mountain Wellness Center in Oakhurst. Contact the Mental Health Plan for more information.

PSYCHIATRIC EMERGENCY TEAM

Emergency services are available 24 hours a day, 7 days a week for individuals who are potentially a danger to themselves or others, or for those who are gravely disabled due to a mental illness. An immediate assessment is provided to determine if psychiatric hospitalization or other care is required.

SUGGESTIONS

Suggestions and opinions are an important part of providing good care. Please give us this feedback by calling the Mental Health Plan at (559) 673-3508 or (888) 275-9779 or using the suggestion boxes in the waiting rooms of Behavioral Health Services programs.

MADERA COUNTY
BEHAVIORAL HEALTH SERVICES

(559) 673-3508
TOLL FREE (888) 275-9779
TTY (800) 735-2929

Cal Relay Services
(English & Spanish)
Dial 711

English Speech to Speech
866-288-1909
Spanish Speech to Speech
866-288-4151

PROCEDIMIENTO DE QUEJA

Lo animamos a que hable sobre sus preocupaciones sobre los servicios de salud mental con su terapeuta o el personal del programa. Usted también puede platicar con el Coordinador de Manejo de Calidad al (559) 673-3508 o (888) 275-9779 o llame al Defensor de Derechos del Paciente al (559) 673-3508 o al Mediador de California del Departamento de Salud Mental al (800) 896-4042 o TTY (800) 735-2922.

Si no se resuelve su asunto sobre cualquier aspecto del servicio, usted puede por cualquiera razón hacer una queja formal con el Coordinador del Manejo de Calidad. Puede verbalmente, poner una queja al llamar al (559) 673-3508 o (888) 275-9779 o completar un formulario de Queja Formal. Formularios de Queja Formal y sobres dirigidos y estampillados son disponibles en el área de recepción de todas las clínicas y oficinas de proveedores.

Puede designar a un representante que actué de su parte si así lo desea. Un representante de consumidores también esta disponible para asistirle al llamar al (559) 673-3508 o (888) 275-9779.

El Partidario de Los Derechos del Paciente puede ser llamado al (559) 673-3508 para asistirle en resolver los agravios.

PROCEDIMIENTO DE APELACIÓN

Si usted desea pedir una “Acción” al Plan de Salud Mental, puede llamar al Coordinador del Manejo de Calidad al (559) 673-3508 o (880) 275-9779 – llamada gratis. Una “Acción” es cuando el Plan de Salud Mental:

- Le niega o limita la autorización de un servicio solicitado.
- Reduce, suspende, o termina un servicio previamente autorizado.
- Niega, por completo o en parte, pago por un servicio.
- Falla de proporcionar servicios de una manera oportuna, según lo determinado por el Plan de Salud Mental.
- Falla de actuar dentro de la marca del tiempo para la disposición de agravios estándares, la resolución de apelaciones estándares, o la resolución de apelaciones apresuradas.

Una Apelación Apresurada puede ser utilizada cuando una decisión se debe tomar rápidamente para proteger la vida, salud, o la capacidad de funcionar a un nivel máximo de los beneficiarios.

Beneficiarios tienen el derecho de solicitar una audiencia Justa del Estado después que el proceso de Apelación ha sido completado. Usted puede ponerse en contacto con el Abogado de los Derechos del Paciente o al Mediador del Estado para asistirle a archivar una Audiencia Justa del Estado. Todas las decisiones de la Audiencia Justa del Estado son finales.

SUS SERVICIOS DE SALUD MENTAL NO SERÁN AFECTADOS DE NINGUNA MANERA AL SOMETER UNA QUEJA, APELACIÓN, O UNA AUDIENCIA JUSTA DEL ESTADO.

Brochures/BHS Services Guide-Spanish-ltr-yellow
Revised: 10-20-09, 6-11-12, 9-6-12, 07-25-13, 07.30.14

SERVICIOS DE COMPORTAMIENTO DEL CONDADO DE MADERA
GUÍA DE SERVICIOS

P. O. Box 1288 / Madera, CA 93639-1288
209 E. 7th St. / Madera, CA 93638

LÍNEAS TELEFÓNICAS DE 24-HORAS

Servicios de Psiquiatría de Emergencia
Ciudad De Madera (559) 673-3508 Línea Gratuita (888) 275-9779

Servicios de Detección y Consulta
Ciudad De Madera (559) 675-7850 Línea Gratuita (888) 275-9779

DONDE PUEDE RECIBIR SERVICIOS DE SALUD MENTAL

Centro De Madera	**209 E 7th St.**	**(559) 673-3508**
Centro De Oakhurst	**49774 Road 426, #D**	**(559) 683-4809**
Centro De Chowchilla	**215 S 4th St**	**(559) 665-2947**

Los centros de consejería listados, están abiertos con cita o sin cita previa en caso de emergencia de 8:00 a.m. - 5:00 p.m., de lunes a viernes.

Si habla un lenguaje diferente o tiene limitaciones físicas, le ayudaremos a encontrar servicios disponibles, apropiados y accesibles.

BIENVENIDOS RESIDENTES DEL CONDADO DE MADERA

Una variedad de servicios de salud mental y programas son disponibles para consumidores de salud mental del Condado de Madera. Servicios de Comportamiento del Condado de Madera provee servicios continuos para niños, jóvenes, adultos y sus familias en tres locaciones igualmente con terapeutas privados contratados en la comunidad. Una lista de proveedores de salud mental esta disponible al solicitarla.

CONSULTA Y REFERENCIA

Servicios pueden ser accesibles al llamar al Plan de Salud Mental (MHP) a los números debajo. Llamadores platicaran con un consejero licenciado de salud mental quien va a proveer una referencia para el programa o/y servicios mas apropiados.

Ciudad de Madera (559) 675-7850
Línea Gratuita (888) 275-9779

SERVICIOS PARA NIÑOS

- Una evaluación es un análisis completo sobre la historia y el estado de salud mental, emocional, y preocupación de comportamiento del individuo. Cuestiones culturales e historia también son identificados. La evaluación es usada para determinar que servicios de salud mental son necesarios.
- Terapia/consejera individual, de familia y grupos son proveídos a personas quien beneficien.
- Servicios psiquiátricos evalúan y siguen a individuos a quien necesitan y que tomen medicamento psicotrópico en buena voluntad.
- Grupos de diagnosis dual son disponibles para adolescentes quien tienen diagnosis relacionado con salud mental y abuso de substancias.
- Servicios de manejo de caso son ofrecidos para ayudar a familias y a individuos para que conecten con recursos de la comunidad.
- Servicios terapéuticos para el comportamiento (TBS) son disponibles para niños/jóvenes hasta la edad de 21 años y son beneficiarios de la Medí-Cal completa. TBS es terapia uno en uno entre el proveedor de salud mental y el beneficiario por un periodo de tiempo breve especifico, designado a mantener la colocación y prevenir hospitalización psiquiátrica con resolviendo la meta del comportamiento y lograr las metas en un tiempo corto.
- Existe un programa colaborativo entre nuestra agencia, el Departamento de Servicios Sociales Del Condado De Madera, el Departamento de Salud Del Condado De Madera, y la Oficina De Educación Del Condado De Madera. El programa ofrece asesoramiento y tratamiento comprensivo para niños que se encuentran en colocación fuera del hogar.
- Programas de Justicia Juvenil proveen consejería individual, en grupo y consejería familiar para jóvenes que son ordenados por el juzgado por medio del Departamento de Libertad Condicional o referidos por la mesa de revisión de asistencia escolar.

SERVICIOS PARA ADULTOS

- Asesoramiento es un análisis completo sobre la historia y el estado de salud mental, emocional y problemas de comportamiento. El asesoramiento determina los servicios de salud mental.
- Terapia individual, familiar y en grupo son proveídos a personas que beneficien.
- Manejo de caso ayuda a consumidores a encontrar y a conectarse con recursos para resolver y aliviar problemas de la vida cotidiana.
- Manejo de caso intensivo ayuda a individuos a estabilizar y mejorar su habilidad de funcionar y a prevenir una posible hospitalización.
- Servicios psiquiátricos evalúan y monitorean a individuos que necesiten y quieran tomar medicamento psicotrópico.
- Tratamiento de diagnosis dual es proveído a individuos que tengan diagnosis relacionadas de salud mental y de substancias.

EQUIPO PSIQUIÁTRICO DE EMERGENCIA

Servicios de emergencia están disponibles las 24 horas del día, 7 días de la semana para personas que posen peligro a sismos o a otros, o para personas que estén gravemente discapacitados debido a una enfermedad mental. Un asesoramiento inmediato es proveído para determinar si hospitalización psiquiatra u otro cuidado es requerido.

SUGERENCIAS

Sugerencias y opiniones son una parte importante al proveer un buen cuidado. Por favor dénos información al llamar al Plan De Salud Mental al número (559)675-7850 o (888)275-9779 o use la caja de sugerencias localizadas en las salas de espera.

SERVICIOS DE COMPORTAMIENTO DEL CONDADO DE MADERA

(559) 673-3508
LLAMADA GRATIS (888) 275-9779
TTY Español (800) 855 3000

Relevo de California (en Español) marcar el 711

Voz a Voz en Español 866-288-4151

ATTACHMENT O

Notice of Action A

Assessment

MHP 21.00 Attachment

MADERA COUNTY
BEHAVIORAL HEALTH SERVICES

POLICY NO.: MHP 21:00

SUBJECT: NOTICE OF ACTION – ASSESSMENT (NOA-A)

POLICY:

A Notice of Action - Assessment (NOA-A) form shall be given to the Medi-Cal beneficiary by the provider at the time the initial assessment determines that medical necessity criteria has not been met for the provision of specialty mental health services.

PURPOSE:

To insure the Medi-Cal beneficiary is notified in a timely manner when a mental health assessment determines that medical necessity criteria is not met.

PROCEDURE:

A. When a provider determines at assessment that a Medi-Cal beneficiary does not meet the medical necessity criteria for specialty mental health services, the provider will give the NOA-A to the beneficiary immediately. The NOA-A will inform the beneficiary of his/her right to a second opinion.

B. The provider will notify the Mental Health Plan (MHP) immediately (same day determination is made). A copy of the NOA-A and assessment will be sent to MHP within one working day to be maintained on file in the MHP office. An additional copy will be sent by the provider to Medical Records to be filed in the beneficiary's chart.

C. If the beneficiary requests a second opinion, MHP will authorize services through Madera County Behavioral Health Services or a contract network provider who is a licensed mental health professional at no cost to the beneficiary.

D. If, upon review, MHP concurs that the beneficiary's diagnosis is not included under Medical Necessity Criteria, an MHP clinician will work with the beneficiary to arrange an alternative source of treatment.

E. The NOA-A will inform the beneficiary of his/her right to a State Fair Hearing after the Appeal Process has been exhausted.

Madera County
Behavioral Health Services

Medi-Cal Specialty Mental Health Services Program
NOTICE OF ACTION
(Assessment)

Date: ___________________________

To: ____, **Medi-Cal Number** ______________________

The Mental Health Plan for Madera County has decided, after reviewing the results of an assessment of your mental health condition, that your mental health condition does not meet the medical necessity criteria to be eligible for mental health services through the plan.

In the Mental Health Plan's opinion, your mental health condition did not meet the medical necessity criteria, which are covered in the state regulations at Title 9, California Code of Regulations (CCR), Section 1830.205, for the reason checked below.

☐ Your mental health diagnosis as identified by the assessment is not covered by the Mental Health Plan (Title 9, CCR, Section 1830.205(b)(1)).

☐ Your mental health condition does not cause problems for you in your daily life that are serious enough to make you eligible for specialty mental health services from the Mental Health Plan (Title 9, CCR, Section 1830.205(b)(2)).

☐ The specialty mental health services available from the Mental Health Plan are not likely to help you maintain or improve your mental health condition (Title 9, CCR, Section 1830.205(b)(3)(A) and (B)).

☐ Your mental health condition would be responsive to treatment by a physical health care provider (Title 9, CCR, 1830.205(b)(3)(C)).

If you agree with the plan's decision and would like information about how to find a provider outside the plan to treat you, you may call and talk to a representative of your Mental Health Plan at the telephone number below or write to Madera County Mental Health Plan at the address below.

If you don't agree with the plan's decision, you may do one or more of the following:

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 the telephone number below or write to the Madera County Mental Health Plan at the address below.

You may 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 or 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.

If you have questions about this notice, you may call and talk to a representative of your Mental Health Plan at 559-675-7926 or toll free 888-275-9779, or write to:

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

If you are dissatisfied with the outcome of your appeal, you may request a state hearing. The other side of this form will explain how to request a hearing.

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-A)
(Evalúo)

Fecha: _______________

A: ____, Numero Medi-Cal ____________________________________.

El plan de salud mental del Departamento de Salud Mental del Condado de Madera, ha repasado los resultados del avalúo de su condición de salud mental. El plan de salud mental ha decidido que su condición no reúne los criterios de la necesidad médica requerida en los reglamentos estatales en Título 9, California Código de Reglamento (CCR), Sección 1830.205, por consiguiente no es elegible para la especialidad de servicios de salud mental cubiertos por el plan. Se verifica la razón(s) abajo.

- ☐ Su diagnosis de la salud mental como identificó por el avalúo no se cubre por el plan de la salud mental (Título 9, CCR, Sección 1830,205 (b) (1)).
- ☐ Su condición de salud mental no causa problemas para usted en su vida diaria que sean bastante serios para hacerlo elegible por especialidad de servicios del plan de salud mental (Título 9, CCR, Sección 1830,205 (b) (2)).
- ☐ La especialidad de servicios de salud mental disponible del plan de salud mental es probable no ayudarlo a mantener o mejorar su condición de salud mental (Título 9, CCR, Sección 1830,205 (b) (3) (Un) y (B)).
- ☐ Su condición de salud mental respondería a tratamiento por un proveedor de cuidado de la salud física (Título 9, CCR, 1830,205 (b) (3) (C)).

Si está de acuerdo con la decisión del plan y gustaría información sobre cómo encontrar un proveedor fuera del plan para que le dé tratamiento, escriba o hable con un representante del plan de salud mental.

Si no está de acuerdo con la decisión del plan o tiene preguntas, haga uno o más de lo siguiente: Pediría que el plan haga arreglos para una segunda opinión acerca de su condición de la salud mental. Para hacer esto, hable con un representante del Plan de Salud Mental al 559-675-7850 o gratis al 888-275-9779, o escriba al:

Plan de Salud Mental
PO Box 1288
Madera, CA 93639

Puede también archivar una apelación con su plan de salud mental (número del teléfono y dirección directamente arriba), o sigua las instrucciones 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 salud mental debe hacer una decisión en su apelación dentro de 45 días de su petición. Puede pedir una apelación expeditiva (apresurada), la cual se debe decidir dentro de 3 días laborales, si usted cree que un retraso causaría problemas serios con su salud mental, incluso problemas con su capacidad de progresar, mantener o recuperar funciones importantes de la vida.

Si tiene preguntas sobre esta aviso, puede hablar con un representante de su Plan de Salud Mental al 559-675-7926 o gratis al 888-275-9779, o escriba al:

Plan de Salud Mental
PO Box 1288
Madera, CA 93639

Si está en desacuerdo con el resultado de su apelación, puede pedir una audiencia estatal. El otro lado de este aviso explica cómo pedir una audiencia.

SUS DERECHOS de la AUDIENCIA

Usted tiene 90 días para pedir una audiencia. Los 90 días empiezan uno de los dos:

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 Expeditivas (Apresuradas)
Normalmente toma aproximadamente 90 días de la fecha de su petición hacer una decisión de audiencia. Si piensa que éste tiempo 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 audiencia apresurada, favor de marcar la 1ª caja en la columna de la mano izquierda de esta página bajo PEDIR 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 así mismo en la audiencia estatal. Puede ser representado también por un amigo, un abogado o alguno otro que elija. Debe hacer arreglos para este representante usted.

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

☐ Cheque aquí si quiere que la audiencia estatal sea expeditiva (apresurada) e incluya la razón abajo.
Aquí este porqué: ____

____

____

☐ Cheque 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 a mí. Mi idioma o dialecto es____________________________________.

Quiero que la persona quien nombro abajo me represente en esta audiencia. Doy mi permiso para que esta persona vea mis archivos y venir a la audiencia por mí.

Nombre: ____

Dirección: ____

____

Número del teléfono: _______________________________________

ATTACHMENT P

Notice of

Action B

Action Other

Than Approval

MHP 22.00

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

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:

559-675-7926
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.

559-675-7926
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 Expeditivas (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: __________________________________

ATTACHMENT Q

Notice of

Action C

Denial of Payment

MHP 23.00

MADERA COUNTY
BEHAVIORAL HEALTH SERVICES

POLICY NO.: **MHP 23:00**

SUBJECT: **NOTICE OF ACTION – POST SERVICE DENIAL OF PAYMENT (NOA-C)**

<u>POLICY</u>:

A Notice of Action – Post Service Denial of Payment (NOA-C) shall be mailed or delivered to the Medi-Cal beneficiary when the Mental Health Plan (MHP) determines that medical necessity criteria were not met for the provision of specialty mental health psychiatric inpatient/outpatient services.

<u>PURPOSE</u>:

To ensure the Medi-Cal beneficiary is notified in a timely manner when MHP determines that medical necessity criteria were not met for psychiatric inpatient/outpatient services previously provided.

<u>PROCEDURE</u>:

A. When services are provided to Medi-Cal beneficiaries prior to authorization by MHP, the Specialty Mental Health provider will submit to MHP a Request for Treatment Authorization. This request must be accompanied by documentation supporting medical necessity criteria.

B. MHP will review the documentation and determine if medical necessity criteria is supported for the psychiatric inpatient and/or outpatient specialty mental health services previously provided.

C. Payment will be denied for any and all services provided if MHP determines medical necessity criteria were not met.

D. An original NOA-C will be mailed or delivered to the beneficiary by MHP within 3 working days of a decision. The NOA-C will inform the beneficiary of his/her right to a State Fair Hearing after the Appeal Process has been exhausted.

E. One copy of the NOA-C will be sent to the provider and another copy maintained on file in the MHP office.

Attachment

COUNTY USE ONLY

TREATMENT AUTHORIZATION REQUEST FOR MENTAL HEALTH STAY IN HOSPITAL

COUNTY DEPARTMENT OF MENTAL HEALTH SERVICES

1. CLAIMS CONTROL NUMBER — F.I. USE ONLY (1)

F.I. USE ONLY (2) (3) (4) (5)

SERVICE CATEGORY

CONFIDENTIAL PATIENT INFORMATION

HOSPITAL USE

ADMIT TAR NUMBER (ORIGINAL AUTHORIZATION NUMBER) (6) — ADMIT DATE (7) — AUTH. EXP. (8) — EMER. ADMIT (9)

PATIENT MEDI-CAL ID NO. (11) — CHECK DIGIT — PEND (12) — SEX (13) — DATE OF BIRTH (14) — AGE (14A)

PROVIDER NUMBER (10) — PROVIDER PHONE NO. ( ) (10A) — VERBAL CONTROL (10B)

PATIENT NAME (14B) — MEDICARE STATUS (15) — OTHER COV. (16)

PROVIDER NAME (10C)

NUMBER OF DAYS REQUESTED (17) — TYPE OF DAYS (18) — RETRO-ACTIVE (19) — DISCHARGE DATE (20) — ADMITTING ICD9-CM (21)

PROVIDER STREET/MAILING ADDRESS

ADMITTING DIAGNOSIS DESCRIPTION (21A)

PROVIDER CITY, STATE AND ZIP CODE

FOR PHYSICIAN- PLEASE PROVIDE SUFFICIENT ESSENTIAL DETAIL TO PERMIT A REASONABLE EVALUATION OF THE LENGTH AND LEVEL OF CARE REQUESTED.

CURRENT DIAGNOSIS (22) — CURRENT ICD9-CM

PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS (22A)

DESCRIBE CURRENT CONDITION REQUIRING HOSPITALIZATION. (22B)

WHAT PLANNED PROCEDURES WILL REQUIRE THIS HOSPITALIZATION, INCLUDE DATES WHEN POSSIBLE. (22C)

HOSPITAL: TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

SIGNATURE OF PROVIDER (22D) — DATE / /

TYPE OR PRINT NAME OF RESPONSIBLE PHYSICIAN

SIGNATURE OF RESPONSIBLE PHYSICIAN X (22E) — DATE / /

COUNTY MEDI-CAL CONSULTANT-VALIDATING INFORMATION AND EXPLANATION (22F)

FOR COUNTY USE ONLY

28 DENIED — 23 (23) APPROVED AS REQUESTED — 24 FROM

29 DEFERRED — 25 APPROVED AS MODIFIED — 26 THRU

27 — ACUTE — ACUTE ADMIN. — SUB ADMIN. VENT — SUB ADMIN. N-VENT.

30 DAYS OF THIS HOSPITALIZATION ARE DENIED (SEE COMMENTS) — 31 JACKSON VS RANK PARAGRAPH CODE

32 — 36 — 39 — DATES

33 — 37 — 40 — OF DAYS

34 — 38 — 41 — DENIED

35 (42) — RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003 (B)

CHART REVIEWS — REVIEW COMMENTS INDICATOR

BY (42A) — COUNTY MEDI-CAL CONSULTANT (43) — ID. NO. (44) — DATE — TAR CONTROL NUMBER 8 9 (44A) 030108 5

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE IDENTIFICATION CARD IS CURRENT BEFORE RENDERING SERVICE.

SEND TO COUNTY MENTAL HEALTH DEPT. - F.I. COPY

18-3 (3/07)

Figure 1. Sample *Request for Mental Health Stay in Hospital* (Form 18-3).

Madera County
Behavioral Health Services

Medi-Cal Specialty Mental Health Services Program
NOTICE OF ACTION
(Post-Service Denial of Payment)

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 ____________________ and your provider says that you received the service on the following date(s): __________________________________.

THIS IS NOT A BILL. YOU WILL NOT HAVE TO PAY FOR THE SERVICE OR SERVICES DESCRIBED ON THIS FORM.

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

- ☐ Your mental health condition as described to us by your provider did 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 as described to us by your provider did 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 provided 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 service you received. To date, the information has not been received.
- ☐ Other: ____

  ____

If you don't agree with the plan's decision, you may:
File an appeal with your Mental Health Plan. To do this, you may call and speak to a representative from your Mental Health Plan at the telephone number listed below or write to the Madera County Mental Health Plan at the address below. You may also 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.

559-675-7926
toll free: 888-275-9779
or write to:
Madera County Mental Health Plan
PO Box 1288
Madera, CA 93639

If you are unhappy with the outcome of your appeal, you may request a state hearing. The other side of this notice explains how to request a hearing. The state hearing will decide if the plan should pay your provider for the service that you already received. Whatever the appeal or state hearing decision, you will not have to pay for the service.

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: ____
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☐ 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-C)
(RECHAZO DE PAGO DESPUÉS DE SERVICIO)

Fecha: _______________

A: ____, Numero de Medi-Cal: ____________________________________.

El plan de salud mental del Departamento de Salud Mental del Condado de Madera

☐ Rechazo ☐ Cambio

La petición de su proveedor de pago por los siguientes servicios:
____

____

Se preparo la demanda por (nombre del proveedor): ____

La demanda original de su proveedor tenía la fecha de _______________ y su proveedor dice que recibió el servicio en la siguiente fecha o fechas: ____.

☐ 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 mental, con excepción de servicios de hospital psiquiátrico para pacientes internos por la siguiente razón (Título 9, CCR, Sección 1830.205):

- ☐ El servicio proveído no se cubre por el plan de la salud mental (Título 9, CCR, Sección 1810.345).
- ☐ El plan de la salud mental pidió información adicional de su proveedor que el plan necesita para aprobar pago del servicio que recibió. A la fechar, no se ha recibido la información.
- ☐ Otro: ____

Si no está de acuerdo con la decisión del plan, puede archivar una apelación con su plan de la salud mental. Para hacer esto, escriba o hable con un representante del plan de salud mental.

559-675-7926
Llamada gratis: 888-275-9779
o escriba a:
Plan de Salud Mental
PO Box 1288
Madera, CA 93639

Otra opción es seguir las instrucciones dentro del folleto de información del plan de salud mental que le han dado. Debe archivar una apelación dentro de 90 días de la fecha de este aviso. **Si está en desacuerdo con el resultado de su apelación, puede pedir una audiencia estatal. El otro lado de este aviso explica cómo pedir una audiencia. La audiencia estatal decidirá si el plan o su proveedor deben pagar por el servicio que ya recibió. Cualquier decisión que tome la apelación o audiencia estatal, no tendrá que pagar por el servicio.**

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 Expeditivas (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: ______________________________

ATTACHMENT R

Notice of

Action D

Delays in Grievance/Appeal

QMP 6.00

MADERA COUNTY
BEHAVIORAL HEALTH SERVICES

POLICY NO.: **QMP 06:00**

SUBJECT: **NOTICE OF ACTION – DELAYS IN GRIEVANCE/APPEAL PROCESSING (NOA-D)**

POLICY:

A Notice of Action – Delays in Grievance/Appeal Processing (NOA-D) shall be mailed or delivered to the Medi-Cal beneficiary when a grievance, appeal or expedited appeal is not resolved within the required time frames.

PURPOSE:

To ensure the Medi-Cal beneficiary is notified in a timely manner when a grievance, appeal or expedited appeal is not resolved within the required time frames.

PROCEDURE:

A. When a grievance, appeal or expedited appeal is not resolved within the required time frames, the Quality Management Coordinator, or designee, will send a NOA-D to the beneficiary. The NOA-D will be mailed to the beneficiary on the date the timeframe expires. It may also be delivered to the beneficiary by the Quality Management Coordinator, or designee.

B. The NOA-D will inform the beneficiary of his/her right to request a State Fair Hearing once the appeal process has been exhausted. It will also inform the beneficiary that the grievance/appeal may continue to be processed.

C. A copy of the NOA-D will be filed with the original grievance or appeal in the Grievance/Appeal file maintained by the Quality Management Coordinator, or designee.

Madera County
Behavioral Health Services

Medi-Cal Specialty Mental Health Services Program
NOTICE OF ACTION
(Delays in Grievance/Appeal Processing)

Date: ___________________________

To: ____, **Medi-Cal Number:** ______________________

The Mental Health Plan for Madera County has not processed your ☐ grievance, ☐ appeal or ☐ expedited appeal on time.

Our records show you made your request on ______________________________.

You requested that ____

____

____

____

We are sorry for the delay in answering your request. We will continue to work on your request and hope to provide you with a decision soon.

If your request was about the denial of or a change in the mental health services you receive from the Mental Health Plan and you do not want to wait for our decision, you may request a state hearing to consider the denial or change. You may also ask that the state hearing consider the reason for the delay.

If your request was about another issue, you may request a state hearing to consider the reason for the delay. The other side of this form explains how to request a state hearing.

This notice is required pursuant to Title 42, Code of Federal Regulations, Part 438, Subpart F.

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-D)
(Demoras en Proceso de Agravio/ Apelación)

Fecha: ___________________

A: ____, Numero de Medi-Cal: ______________________________

El plan de salud mental del Departamento de Salud Mental del Condado de Madera, no ha procesado su agravio, su apelación, o su apelación expeditiva (apresurada) a tiempo. Nuestros archivos muestran que hizo su demanda en __________________________.

Usted pidio que: ____

____

____

____

Sentimos mucho por la tardanza en contestar su petición. Continuaremos trabajando en su petición y esperamos proveer le una decisión muy pronto.

Si su petición trataba de rechazo de proveer servicios o un cambio en los servicios de salud mental que usted recibe del plan de salud mental y usted no quiere esperar para nuestra decisión, puede pedir una audiencia estatal para considerar la demora o cambio. Puede también pedir audiencia estatal para considerar la razón por el retraso.

Si su petición se trataba de otra situación, puede pedir una audiencia estatal para considerar la razón por el retraso. El otro lado de esta forma aclara cómo pedir una audiencia estatal.

Este aviso se requiere de acuerdo a Titulo 42, Código de Reglamentos Federales, Parte 438, Sub-parte F.

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 Expeditivas (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 1[a] 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: __________________________________

ATTACHMENT S

Notice of

Action E

Timely Service Delivery

MHP 24.00

MADERA COUNTY
BEHAVIORAL HEALTH SERVICES

POLICY NO.: **MHP 24:00**

SUBJECT: **NOTICE OF ACTION – E**

POLICY:

A Notice of Action – E (NOA-E) shall be mailed or delivered to the Medi-Cal beneficiary when the Mental Health Plan (MHP) has not provided services within the timeframes established by MHP.

PURPOSE:

To ensure the beneficiary receives notice that services have not been provided in a timely manner, the request is being processed and that the beneficiary may file an Appeal.

PROCEDURE:

A. The original NOA-E will be mailed to the beneficiary and a copy placed in the MHP files within five (5) working days of notification that services have not been provided.

B. The NOA-E will inform the beneficiary of his/her right to a State Fair Hearing after the Appeal Process has been exhausted. Furthermore, it will inform the beneficiary that the request may continue to be processed.

Attachment

Approved by BHS Director: Signature on File	Date: 3-16-08	Effective Date: 10-01-03	Revision Date: 11-09-04, 10-24-07, 1-16-08

Madera County
Behavioral Health Services

Medi-Cal Specialty Mental Health Services Program
NOTICE OF ACTION
(Lack of Timely Service)

Date: ___________________________

To: ____, **Medi-Cal Number** _______________________

The Mental Health Plan for Madera County has not provided services within __________ working days of the date of the initial service request.

Our records show that you requested services, or services were requested on your behalf on _________________________.

The following services were requested by you or on your behalf:

____

____

____

We are sorry for the delay in providing timely services. We are working on your request and hope to provide you with the requested service(s) soon.

You may request a state hearing to consider the reason for the delay.

The other side of this form explains how to request a state hearing.

This notice is required pursuant to Title 42, Code of Federal Regulations, Part 438, Subpart F.

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-E)
(FALTA DE SERVICIO OPORTUNO)

Fecha: ________________________

A: ____ Número de Medi-Cal: ________________________

El plan de salud mental del Departamento de Salud Mental del Condado de Madera, no ha proporcionado servicios dentro de __________ días laborales de la fecha inicial de que usted pidió servicio. Nuestros archivos muestran que pidió servicios, o se pidieron en su nombre, ____.

Los servicios siguientes fueron pedidos por usted o en su nombre:
____

____

____

____

Sentimos mucho con respecto a la tardanza en proporcionar servicios oportunos. Trabajamos en su petición y esperamos proveer a usted con el servicio(s) pedido pronto. Puede pedir una audición estatal que considere la razón por el retraso. El otro lado de esta forma aclara cómo pedir una audición estatal.

Este aviso se requiere de acuerdo a Titulo 42, Código de Reglamentos Federales, Parte 438, Subparte F.

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 Expeditivas (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: ______________________

ATTACHMENT T

Credentialing

Policies

CRD 1.00 – 7.00

MADERA COUNTY
BEHAVIORAL HEALTH SERVICES

POLICY NO.: **CRD 01:00**

SUBJECT: **CREDENTIALING PROCESS FOR DOCTORS AND NETWORK PROVIDERS**

REFERENCE:

- CFR, title 42, section 438.230(a)

POLICY:

All providers entering into a contract with the Madera County Mental Health Plan (MHP) must be credentialed by Madera County Behavioral Health Services (BHS) and have a verified and approved credentialing packet on file.

At the discretion of the Madera County Behavioral Health Credentialing Committee; the Committee can accept the credentialing process of a contracted hospital/agency and /or conduct a partial or complete internal credentialing review. The hospital/agency must submit a letter verifying the credentialed status of the physician(s) used by that particular hospital/agency. The physician will be credentialed upon affirmation by the Credentialing Committee.

PURPOSE:

To establish a credentialing process to assure the competency of mental health professionals who contract with the Madera County Mental Health Plan (MHP) to provide mental health services to Madera County Medi-Cal beneficiaries.

PROCEDURE:

I. Application Process.

A. Each provider who expresses interest in contracting to be a network provider for Madera County Behavioral Health Services (BHS) will be sent an application packet consisting of the following:

1. Application to Participate As Provider (CRD 01.A1)
2. Confidential Certification (CRD 01.A2)
3. Instructions for Completion of Application (CRD 01.A3)
4. Application Check-Off List (CRD 01.A4)
5. Authorization to Release Credentialing Information (CRD 01.A5)

B. Providers will return completed forms to the BHS Credentialing Coordinator.

C. The application must contain the following:

1. Completed questionnaire which includes copies of the following documents:

   - Valid, current and unrestricted licensure to practice in California.
   - Current DEA Certificate (if appropriate)
   - Evidence of current professional liability coverage which, meet or exceeds MHP minimum limits.

2. Signed release granting MHP access to records for credentialing purposes of any medical society, medical board, college of medicine, hospital, malpractice insurance carrier or any other institution, organization or entity which does or may maintain records concerning the applicant's practice of medicine.

3. Statement in writing by the applicant regarding:

   a. Physical and mental health status.

   b. Lack of impairment due to chemical dependency.

   c. History of loss of license.

   d. History of felony convictions.

   e. History of limitation of privileges or disciplinary action.

   f. Work history.

   g. History of professional liability claims.

4. Signed attestation by applicant to the correctness and completeness of the application.

D. Accepting the credentialing process of a contracted hospital/agency.

1. The hospital/agency must submit a letter verifying the credentialed status of the physician(s) used by that particular hospital/agency.

2. In lieu of the above credentialing packet, the contracted hospital/agency must submit the "Managed Care Mental Health Plan Application Check List" (Attachment 8, CRD: 01.A8) for each applicant to the Credentialing Coordinator, including the Confidential Certification signed by the applicant.

II. General Criteria and Standards

Each provider applying for credentialing by Madera County Mental Health Plan (MHP) shall meet the following criteria as applicable:

A. Valid, current, unrestricted California license.

B. Hospital/Facility Privileges: (if appropriate)

1. Physicians will have current unrestricted staff clinical privileges and admitting

privileges granted by an MHP participating hospital within the service area.

C. Valid, current Drug Enforcement Agency (DEA) registration. (if appropriate)

D. Current professional liability coverage which meets or exceeds MHP limits.

E. Absence of a history of involvement in malpractice suit, arbitration, or settlement within the past two years. In the case of a provider with such history, there must be evidence that the history does not demonstrate probable future sub-standard professional performance.

F. Absence of a history of denial, suspension, restriction, or termination of hospital privileges within the past two years; or in the case of a provider with such history, evidence that this history does not currently affect provider's ability to perform professional duties for which provider is contracted or does not demonstrate probable future sub-standard performance.

G. Absence of a history of disciplinary actions within the past two years affecting provider's professional license, DEA or other required certifications; or for providers with such history, evidence that this history does not currently affect provider's ability to perform professional duties for which provider is contracted or does not demonstrate probable future sub-standard performance.

H. Absence of a history of felony convictions within the past two years; or, for a provider with such history, evidence that the nature of the conviction does not affect provider's current ability to perform the professional duties for which provider is contracted or does not demonstrate probable future sub-standard care.

I. Absence of a history of sanctions by regulatory agencies, including Medicare/Medicaid sanctions, within the last two years; or, for a provider with such a history, evidence that applicant is not currently sanctioned or prevented by a regulatory agency from participating in federal or state sponsored programs or evidence that past sanctions do not demonstrate probable future sub-standard performance.

J. Absence of a history of chemical dependency/substance abuse within the past two years for those providers who have such history, evidence that the provider is participating in, or has completed, a prescribed, monitored treatment program and that no current chemical dependency or substance abuse exists that would affect provider's ability to adequately perform the professional duties for which provider is contracted.

K. Absence of a physical or mental health condition that would impair or would be likely to impair provider's ability to adequately perform the professional duties for which provider is contracted.

Meeting these Criteria and Standards does not automatically entitle an applicant to participate in the Plan.

III. Application Review by Credentialing Coordinator

A. The Credentialing Coordinator will review the application for completeness and verify that the confidentiality/release form is signed and dated.

   1. If an application is incomplete, it will be returned to the applicant for completion.

   2. If application is complete, a file will be created for that applicant and all of the following will be verified by the National Data Bank (NDB):

      - Licenses
      - Insurance
      - Education including graduation from an accredited professional school, or highest training program applicable to the academic degree, discipline, and licensure of the mental health professional applicant.

   3. A copy of query from the NDB will be kept with application in the applicant's file.

   4. Applicant will be notified if a need for more documentation is indicated.

   5. The completed folder will be presented to the Credentialing Committee for review and approval at the next regular meeting or a special meeting will be called.

IV. Application Review by Credentialing Committee

A. The Credentialing Committee will review the folders prepared by the Credentialing Coordinator, asking questions about information that is unclear.

B. The Committee will decide whether or not each application for credentialing is approved.

   1. If application is approved, the mental health professional applicant will be notified by the Credentialing Coordinator by mail that credentialing has been approved.

      a. A Provider Manual and County Contract will be sent to the provider or group for signature.

      b. The MHP will contact the provider once the signed contract is returned in order to provide orientation and training.

   2. If the application is not approved, a notice will be sent to the provider describing why the application was not approved and explaining the appeal process procedures.

      a. Providers shall not be excluded solely because of the provider's type of license or certification.

      b. Providers who serve high-risk populations or specialize in mental health conditions that require costly treatment will not be discriminated

against.

V. Initiation of Contract

A. The Credentialing Coordinator will prepare a "Notice of New Provider" form (CRD 01.A6), completing Section 1 based on information in the Applicant folder.

B. Form will be sent to Quality Management (QM) Supervisor (or designee) who will complete Section 2.

C. QM Supervisor will send the form to Contract Analyst who will initiate a contract and send two copies to the applicant/ for signature.

D. Contracts will not be initiated for applicants when BHS is accepting the credentialing process of a contracted hospital.

E. Contract Analyst will send completed form to Anasazi Support Staff for set up of provider numbers.

F. Anasazi Support Staff will return the form to Credentialing Coordinator to update Provider List.

VI. Appeal Process

A. An applicant may request a review and reconsideration of an adverse Credentialing Committee decision by contacting the Behavioral Health Services Director.

B. The Behavioral Health Services Director shall appoint an ad hoc committee consisting of three (3) members of the BHS Quality Management Committee.

C. The ad hoc committee will meet with the applicant to review the application folder and the Credentialing Committee's findings.

D. The ad hoc committee will make a decision regarding the appropriateness of the application for credentialing and notify the Behavioral Health Services Director

E. The Behavioral Health Services Director will consider the findings and make a final decision regarding applicant's credentialing.

F. Applicant will be notified by mail of the final decision.

VII. Subcontractor Relationships and Delegation

A. BHS is accountable and will oversee any functions and responsibilities that it delegates to any subcontractor.

B. Before any delegation, BHS will evaluate the prospective contractor's ability to perform the activities to be delegated. BHS will have a written agreement with the subcontractor specifying the activities and report responsibilities delegated to the subcontractor and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

C. BHS will monitor the subcontractor's performance on an ong oing basis and subject it to a formal review in accordance to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations.

D. If BHS identifies deficiencies or areas for improvement, BHS and t he subcontractor will take corrective action.

APPLICATION TO PARTICIPATE AS PROVIDER
MADERA COUNTY MENTAL HEALTH PLAN

IDENTIFYING INFORMATION

Last Name ____ First Name ____ MI ____ SSN or Tax ID # ____

Gender: ________ Birth Date: ______________ License: MD ☐ Psychologist ☐ LCSW ☐ LMFT ☐

Address ____ Phone ____ Fax ____

Checks to be made out as follows:

Name ____ Address ____ City / State / Zip ____

Population served: Children 5 & under: ☐ Children 6 to 12: ☐ Adolescents: ☐ Adults: ☐ Older Adults: ☐

Service area(s) offered: Individual: ☐ Family: ☐ Group: ☐ Medications: ☐ Psych Testing: ☐

Inpatient: ☐ Other: ☐ (specify) ____________

Days Available: Mon ☐ Tues ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun ☐

Hours Available: ____ ____ ____ ____ ____ ____ ____

List languages spoken in addition to English: ____________

Ethnic, Racial & Culture Specific Specialties: ____________

Are you accepting new clients? Yes ☐ No ☐

LICENSURE

State	License Number	Type of License	Expiration Date

M.D.s please complete if applicable

Medi-Cal Provider #:	Medicare UPIN:	NPI#:
DEA Number:	DEA Expiration Date:	
Taxonomy #:	Taxonomy Classification:	

PROFESSIONAL LIABILITY

Insurance Carrier	Policy #	Per claim amt	Aggregate amt	Expiration Date
		$	$	

[ ] Yes [ ] No Have any judgments been made against you, or settlements been agreed to, in professional liability cases, or are there any filed and served professional liability lawsuits pending against you.

[ ] Yes [ ] No Has your professional liability insurance ever been terminated, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance?

Madera County requires contractor to carry malpractice liability insurance of at least one million dollars ($1,000,000.00) per person per occurrence, and three million dollars ($3,000,000.00) in aggregate, insuring against professional errors and omissions (malpractice) in providing mental health services and for the protection of the interests and property of contractor, his/her officers and employees, County, its officers and employees, and Medi-Cal members.

ATTESTATION QUESTIONS

[ ] Yes [ ] No Has your clinical license or narcotic registration ever been revoked, suspended or limited, or have you received a letter of reprimand, or is there action pending?

[ ] Yes [ ] No Have you been the recipient of adverse actions or surrendered clinical privileges while under investigation for possible actions, such as revocation, suspension, limitation, disciplinary review action, denial, canceling, or is any such action pending:

[ ] by Medicare, Medicaid or any public program?
[ ] a hospital medical staff, clinical group, independent practice association, health plan, HMO, PPO, private payer, professional association, professional school faculty or other health delivery entity or system?
[ ] by a specialty board?

[ ] Yes [ ] No Have you ever been convicted of a felony?

[ ] Yes [ ] No Do you have any physical or mental conditions which impair your ability to practice?

MADERA COUNTY MENTAL HEALTH PLAN

CONFIDENTIAL CERTIFICATION

I, the undersigned, hereby attest that the information given in or attached to this Application is accurate, complete and fairly represents the current level of my training, experience, capability, and competence to practice at the level requested. I specifically authorize you and your authorized representatives to consult with any third party which may have information bearing on the subject matter addressed by this Application and to inspect or obtain any reports, records, recommendations, or other documents or disclosures from third parties that may be material to the questions in the Application. I also specifically authorize any third parties to release information to you and/or your authorized representatives upon request. I hereby release you and/or your authorized representatives, and any third parties, from any liability for any reports, records, recommendations, or other documents or disclosures involving me that are made, requested, or received by you and/or your authorized representatives to, from, or by any third parties, including otherwise privileged or confidential information, made or given in good faith and relating to the subject matter addressed by this Application.

I warrant that I have the authorization to sign this Application, on my own behalf, or on behalf of any entity or organization for which I am signing in a representative capacity. I understand that if this Application is accepted by the Madera County Mental Health Plan, I will be bound by the terms of the Mental Health Plan, of which this Application is a part.

ANY INFORMATION ENTERED INTO THIS APPLICATION WHICH SUBSEQUENTLY IS FOUND TO BE FALSE COULD RESULT IN REFUSAL TO ENTER INTO A CONTRACT WITH YOU OR TERMINATION OF CONTRACT.

YOUR SIGNATURE IS REQUIRED TO COMPLETE THIS APPLICATION. STAMPED SIGNATURES ARE NOT ACCEPTABLE.

Signature: ______________________________ Name (Print): ______________________________

Title: ______________________________ Date: ______________________________

Please return this information to:

Madera County Mental Health Plan
Attn: Credentialing Coordinator
P. O. Box 1288
Madera, CA 93639-1288
(559) 673-3508
FAX (559) 675-7758

INSTRUCTIONS FOR COMPLETION OF APPLICATION TO PARTICIPATE AS PRACTITIONER IN MH PLAN OF MADERA COUNTY

General Instructions

- Application must be typed or printed legibly.
- All questions must be completed; incomplete applications will be returned.
- If there is insufficient room for any questions, additional sheets may be attached. Reference the attachment in the question being answered.

Identifying Information

- Checks will be made out to the practitioner or organization identified on the form.

Licensure

- List California license first.
- If licensure in a state is no longer active, place the date it became inactive in the "expiration date" column.
- If you do not have one of the identified numbers, leave the section blank.
- Attach a copy of California license.

Malpractice Liability Insurance

- If the answer to any of the questions is "yes," provide full details on an attached sheet.
- Attach a copy of malpractice insurance.

Attestation Questions

- If the answer to any of the questions is "yes," provide full details on an attached sheet.

Return this form to the address in the cover letter with:

- A photocopy of the California license and DEA certificate (if applicable)
- Proof of liability coverage
- A current *curriculum vitae*

If you have questions regarding this application, please call:

Margaret E. Graham, Credentialing Coordinator
(559) 673-3508
FAX (559) 675-7758

MANAGED CARE MENTAL HEALTH PLAN APPLICATION

CHECK-OFF LIST

NAME AND TITLE: ____

_________ APPLICATION

_________ CURRICULUM VITAE (RESUME)

_________ COPY OF STATE LICENSE Expiration Date:_______________

_________ MEDICAID/MEDI-CAL PROVIDER NUMBER

_________ LIABILITY INSURANCE VERIFICATION Expiration Date: ______________

_________ DEA CERTIFICATE (MDs ONLY) Expiration Date: ______________

_________ CONTINUING EDUCATION VERIFICATION

_________ SIGNED INFORMATION RELEASE FORM (Confidential Certification)

_________ (2) REFERENCES - Attach or list below current references with addresses.

COMMENTS: ____

____

____

____

AUTHORIZATION TO RELEASE CREDENTIALING INFORMATION

I, ______________________________ give my permission for ____________________
(print name) (County Releasing Information)

County Mental Health Plan to release a copy of my Credentialing information to Madera County Mental Health Plan for my credentialing/application process.

During such time as this application is being processed, I agree to update the application should there be any changes in the information provided which may affect the application or its outcome.

Name (print): ____________________________ License: ______________________

Signature: ______________________________ Date: ________________________

Address: ____

Notice of New Provider
(PLEASE ROUTE AS INDICATED)

1. CREDENTIALING COORDINATOR

(Applicant Name and License) (SS# / Tax ID #)

(Address) (City/State/Zip)

(Phone Number) (Other Languages Spoken)

Effective date DEA License # expiration date — Group Provider Name

Effective date Professional License expiration date

NPI# & Medi Care UPIN or PTAN# — Taxonomy Number & Description

(Credentialing Coordinator Signature/Date) (Date Credentialing Completed)

License & Insurance Certificate Attached? ☐ Yes ☐ No

Accepting new clients? ☐ Yes ☐ No

Population served:

☐Children 5 & under ☐Children 6 to 12 ☐Adolescents ☐Adults ☐Older Adults

Service area(s) offered:

☐Individual ☐Family ☐Group ☐Meds ☐Psych Testing

☐Inpatient only ☐Other (specify ____________________

2. CONTRACT SPECIFICATIONS (Mental Health Plan Coordinator)

Preauthorization Required? ☐ Yes ☐ No

(QM Supervisor/Designee Signature/Date)

3. DIRECTOR OR DESIGNEE

(Director or Designee Signature/Date) ($ Amount of Contract)

(Date Contract Signed and Completed) (Provider Services Start/End of Contract Dates)

4. FISCAL STAFF FOR SETUP (KEEP COPY IN BINDER)

(Provider ID) (Provider Prefix)

(Fiscal Staff Signature) (Date)

5. RETURN TO CREDENTIALING COORDINATOR TO UPDATE PROVIDER LIST/FILE

MADERA COUNTY MENTAL HEALTH PLAN
AUTHORIZATION TO RELEASE INFORMATION

I, the undersigned, hereby attest that the information given in or attached to this Recredentialing Questionnaire is accurate, complete, and fairly represents the current level of my training, experience, capability, and competence to practice at the level requested. I specifically authorize Madera County Mental Health Plan (MHP) and its authorized representatives to communicate and exchange information with any third party which may have information bearing on the subject matter addressed by this Recredentialing Questionnaire and to inspect or obtain any reports, records, recommendations, or other documents or disclosures from third parties that may be material to the questions in the Recredentialing Questionnaire. I also specifically authorize any third parties to release information to you and/or its authorized representatives upon request. I hereby release the MHP and/or its authorized representatives and any third parties, from any liability for any reports, records, recommendations, or other documents or disclosures involving me that are made, requested, or received by the MHP and/or its authorized representatives to, from, or by third parties, including otherwise privileged or confidential information, made or given in good faith and relating to the subject matter addressed by this Recredentialing Questionnaire. I am aware that requests for information may include confirmation of staff status and associations, dates of tenure, malpractice history and amounts of coverage and other information obtained as a result of credentialing verification requests.

I warrant that I am authorized to sign this Recredentialing Questionnaire, on my own behalf, and on behalf of any entity or organization for which I am signing in a representative capacity. I understand that if this Recredentialing Questionnaire is accepted by Madera County Mental Health Plan, I will be bound by current State and Federal regulations.

I release from liability the MHP and its representatives for their acts performed in connection with evaluating my re-application and my credentials and qualifications; and I hereby release from any liability any and all individuals and organizations who provide information to the MHP concerning my professional competence, ethics, character and other qualifications for provider panel membership.

I hereby affirm that the information furnished by me to the MHP is true to the best of my knowledge and in good faith. I understand that willful and substantial omissions or misrepresentations may result in denial, modification or revocation of my provider panel membership and/or clinical privileges.

I, (Please print name) ____.DO HEREBY MAKE FORMAL REAPPLICATION FOR PROVIDER PANEL MEMBERSHIP WITH THE MENTAL HEALTH PLAN OF MADERA COUNTY.

YOUR SIGNATURE IS REQUIRED TO COMPLETE THIS RECREDENTIALING QUESTIONNAIRE. STAMPED SIGNATURES ARE NOT ACCEPTABLE.

_______________________________ _______________________

Signature and Title Date

THIS FORM MUST BE RETURNED TO THE MENTAL HEALTH PLAN OFFICE.

MADERA COUNTY BEHAVIORAL HEALTH SERVICES
MANAGED CARE MENTAL HEALTH PLAN
APPLICATION CHECK LIST
(559) 675-7926 FAX (559) 675-7638

NAME AND TITLE: ____

ORGANIZATION NAME: ____

ORGANIZATION TYPE: ____

WORK ADDRESS: ____

CITY, STATE, ZIP CODE: ____

_______ GENDER

________ DATE OF BIRTH

________ STATE LICENSE NUMBER & STATE Expiration Date: _____________

________ MEDICAID/MEDI-CAL PROVIDER NUMBER

____ ____ DEA NUMBER (MDs ONLY) Expiration Date: _____________

________ NATIONAL PROVIDER IDENTIFIERS (NPI)

________ SOCIAL SECURITY NUMBER

________ UPIN NUMBER Expiration Date: _____________

________ PROFESSIONAL LIABILITY (MALPRACTICE) Expiration Date: _____________

________ TAXONOMY NUMBER TAXONOMY CLASSIFICATION: _____________

________ PROFESSIONAL SCHOOL(S) & YEAR OF GRADUATION

____

____

RETURN FORM TO: Madera County Behavioral Health Services
Mental Health Plan
Credentialing Coordinator
P.O. Box 1288
Madera, CA 93639

MADERA COUNTY MENTAL HEALTH PLAN

CONFIDENTIAL CERTIFICATION

I, the undersigned, hereby attest that the information given in or attached to this Application is accurate, complete and fairly represents the current level of my training, experience, capability, and competence to practice at the level requested. I specifically authorize you and your authorized representatives to consult with any third party which may have information bearing on the subject matter addressed by this Application and to inspect or obtain any reports, records, recommendations, or other documents or disclosures from third parties that may be material to the questions in the Application. I also specifically authorize any third parties to release information to you and/or your authorized representatives upon request. I hereby release you and/or your authorized representatives, and any third parties, from any liability for any reports, records, recommendations, or other documents or disclosures involving me that are made, requested, or received by you and/or your authorized representatives to, from, or by any third parties, including otherwise privileged or confidential information, made or given in good faith and relating to the subject matter addressed by this Application.

I warrant that I have the authorization to sign this Application, on my own behalf, or on behalf of any entity or organization for which I am signing in a representative capacity. I understand that if this Application is accepted by the Madera County Mental Health Plan, I will be bound by the terms of the Mental Health Plan, of which this Application is a part.

ANY INFORMATION ENTERED INTO THIS APPLICATION WHICH SUBSEQUENTLY IS FOUND TO BE FALSE COULD RESULT IN REFUSAL OF APPROVED CREDENTIALING STATUS WITH MADERA COUNTY BEHAVIORAL HEALTH SERVICES.

YOUR SIGNATURE IS REQUIRED TO COMPLETE THIS APPLICATION. STAMPED SIGNATURES ARE NOT ACCEPTABLE.

Signature: ______________________________ Name (Print): ______________________________

Title: ______________________________ Date: ______________________________

Please return this information to:

Madera County Mental Health Plan
Attn: Credentialing
P. O. Box 1288
Madera, CA 93639-1288
(559) 675-7926
FAX (559) 675-7638

MADERA COUNTY
BEHAVIORAL HEALTH SERVICES
MENTAL HEALTH PLAN

DENNIS P KOCH, MPA
MENTAL HEALTH DIRECTOR
ALCOHOL/DRUG ADMINISTRATOR

P.O. BOX 1288
MADERA, CA 93639-1288
PHONE (559) 673-3508
FAX (559) 675-4999

CREDENTIALING VERIFICATION

Credentialing Representative:

Please verify if _____ is credentialed by your facility.

☐ Yes ☐ No

If yes, what is the credentialing date? ____________

____________________________________ ________________
Signature of Credentialing Representative Date

Please sign, date and fax or email this form to:

Margaret E. Graham
Credentialing Coordinator
Madera County Behavioral Health
PO Box 1288
Madera CA 93639

Email: margaret.graham@co.madera.ca.gov
Fax: (559) 675-7758

MADERA COUNTY
BEHAVIORAL HEALTH SERVICES

DENNIS P. KOCH, MPA
DIRECTOR OF BEHAVIORAL HEALTH SERVICES
- **MENTAL HEALTH DIRECTOR**
- **ALCOHOL/DRUG PROGRAM ADMINISTRATOR**

P.O. BOX 1288
MADERA, CA 93639-1288
PHONE (559) 673-3508
FAX (559) 675-7758
CONFIDENTIAL CLIENT INFORMATION FAX (559) 661-2818

RE: ____ (Mental Health Care Professional)

The above-referenced mental health care professional has applied for membership to the Madera County Mental Health Plan as a provider of outpatient services and has listed you as a reference. Your answers on the attached questionnaire, as presented by our Credentials Health Care Provider Committee, will be greatly appreciated.

A signed copy of the Consent and Release from Liability Statement executed by the provider in connection with this application is on file. Please return a signed hard copy of the attached document at your earliest convenience.

Or, you may submit a letter of reference, pertaining to the items listed below.

Thank you for your attention to this matter.

Sincerely,

Margaret Graham
Credentialing Coordinator

REFERENCE QUESTIONNAIRE

Candidate's Name: ______________________________

1. How long have you known the candidate? ______________________________

2. I know the candidate
   ____ As a friend
   ____ Socially
   ____ Professionally
   ____ Other (describe) ______________________________

3. My knowledge of the candidate's professional competence is based on:
   ____ Personal observation from close working relationship
   ____ As a teacher/student (please circle one)
   ____ Long-time observations "from a distance"
   ____ Short-time observations "from a distance"
   ____ Hearing much feedback from respected colleagues who know his/her work more closely than I.
   ____ By vague reputation
   ____ Other (describe) ______________________________

4. Please describe your knowledge of the candidate's professional competence:

	Superb	Good	Fair	Poor	Unknown
a. Understanding his/her field	☐	☐	☐	☐	☐
b. Common sense in his/her field	☐	☐	☐	☐	☐
c. Dedication and industry	☐	☐	☐	☐	☐
d. Humaneness & compassion in to patients	☐	☐	☐	☐	☐
e. Availability to patients	☐	☐	☐	☐	☐
f. Excellence & diligence in maintaining medical records	☐	☐	☐	☐	☐

5. Please describe your perception of his/her integrity, commitment and honesty.

a. In the field of medicine	☐	☐	☐	☐	☐
b. In family and social areas	☐	☐	☐	☐	☐
c. In the general community	☐	☐	☐	☐	☐

Note: If the response to any of the above questions is fair or poor please supply a written explanation, giving full details.

6. Please describe any areas that could be future problems (or have been problems in the past). If no problems are identified, please so state.
   a. Emotional stability
      Professional ______________________________
      Private ______________________________
   b. Habit problems
      Alcohol ______________________________
      Drugs ______________________________
      Other (please describe) ______________________________
   c. Physical health problems ______________________________

7. Your recommendation to the Credentialing Committee:
   ☐ Unqualified, enthusiastic endorsement
   ☐ Enthusiasm for him/her is lukewarm or negative
   ☐ Other comments or choices not listed above ______________________________

8. Additional comments: ______________________________

____

____

______________________________ ______________________________
Signature of person completing this form — Print Name, Title, Date

Form Revised: 07-13-05

MADERA COUNTY
BEHAVIORAL HEALTH SERVICES

POLICY NO.: **CRD: 02:00**

SUBJECT: **REVIEW/APPROVAL OF NETWORK PROVIDER APPLICATION PROCESS**

POLICY:

All applications to become a Network Provider will be reviewed by the Credentialing Committee.

PURPOSE:

To delineate procedure to review applications to become a network provider for Madera County Mental Health Plan.

PROCEDURE:

I. The credentialing Committee consists of:

   A. The Behavioral Health Services Director

   B. The Credentialing Coordinator

   C. The Division Manager for Managed Care

   D. The Staff Services Manager

   E. The Supervisor of MHP

   F. The QM Coordinator

II. The Credentialing Committee meets quarterly or as needed.

   A. The Credentialing Coordinator maintains committee minutes.

III. Each application is reviewed and all documents are reviewed for completeness and accuracy. Applications are established and reviewed, following all internal as well as federal and state requirements.

IV. If application is approved, the mental health professional applicant will be notified by mail that credentialing has been approved.

   A. A Provider Manual and County Contract will be sent to the provider for signature.

   B. The MHP will contact the provider once the signed contract is returned to schedule orientation and training.

V. If the application is not approved, a notice will be sent to the provider describing why the application was not approved and explaining the appeal process procedures.

   A. Practitioners shall not be excluded solely because of the practitioner's type of

license or certification.

B. Providers who serve high-risk populations or specialize in the conditions that require costly treatment will not be discriminated against.

MADERA COUNTY
BEHAVIORAL HEALTH SERVICES

POLICY NO.: **CRD: 03:00**

SUBJECT: **CREDENTIALING CRITERIA OF NETWORK PROVIDER**

POLICY:
Madera County Mental Health Plan (MHP) ensures that Medi-Cal beneficiaries receive services consistent with recognized community standards from qualified mental health practitioners.

PURPOSE:
To support the credentialing process of the MHP by establishing objective credentialing criteria for professional providers.

PROCEDURE:
An applicant for initial credentialing as a MHP provider shall meet the following standards:

STANDARDS		MEASURE
Completion of Provider Application.		On file; confirmed by Credentialing Coordinator.
Current professional license, evidence of any Board Certification, BNDD/DEA Certificate (if appropriate).		MHP confirmation with issuing authority.
Evidence of liability coverage as stipulated in contract.		Submission of evidence of coverage; review by Credentialing Committee; further review by legal and R isk Management staff as needed.
National Data Bank Inquiry		On file
Curriculum Vitae.		On file
Office of Inspector General / Exclusion List		On file

Note: See Also CMP 03:05 as to Ineligible Persons Screening Policy and Procedure

MADERA COUNTY
BEHAVIORAL HEALTH SERVICES

POLICY NO.: **CRD: 04:00**

SUBJECT: **RECREDENTIALING PROCESS OF NETWORK PROVIDER**

POLICY:

The following recredentialing criteria shall apply to all participating providers, as applicable, to be considered for recredentialing every two years.

PURPOSE:

To establish a recredentialing process to assure the competency of mental health professionals who contract with Madera County Mental Health Plan (MHP) to provide mental health services to Madera County Medi-Cal beneficiaries.

PROCEDURE:

I. General Criteria and Standards

Each provider responding to a re-credentialing questionnaire from the Mental Health Plan (MHP) shall meet the following criteria as applicable.

A. Valid, current, unrestricted California license.

B. Hospital/Facility Privileges: (if appropriate)

1. Physicians will have current unrestricted staff clinical privileges and admitting privileges granted by an MHP participating hospital within the service area.

C. Valid, current Drug Enforcement Agency (DEA) registration. (if appropriate)

D. Current professional liability coverage which meets or exceeds MHP limits.

E. Absence of a history of involvement in malpractice suit, arbitration, or settlement within the past two years; in the case of a provider with such history, evidence that the history does not demonstrate probable future sub-standard professional performance.

F. Absence of a history of denial, suspension, restriction, or termination of hospital privileges within the past two years; or in the case of a provider with such history, evidence that this history does not currently affect provider's ability to perform professional duties for which provider is contracted or does not demonstrate probable future sub-standard performance.

G. Absence of a history of disciplinary actions within the past two years affecting provider's professional license, DEA or other required certifications; or for providers with such history, evidence that this history does not currently affect

provider's ability to perform professional duties for which provider is contracted or does not demonstrate probable future sub-standard performance.

H. Absence of a history of felony convictions within the past two years; or, for a provider with such history, evidence that the nature of the conviction does not affect provider's current ability to perform the professional duties for which provider is contracted or does not demonstrate probable future sub-standard care.

I. Absence of a history of sanctions by regulatory agencies, including Medicare/Medicaid sanctions, within the last two years; or, for a provider with such a history, evidence that applicant is not currently sanctioned or prevented by a regulatory agency from participating in federal or state sponsored programs or evidence that past sanctions do not demonstrate probable future sub-standard performance.

J. Absence of a history of chemical dependency/substance abuse within the past two years for those providers who have such history, evidence that the provider is participating in, or has completed, a prescribed, monitored treatment program and that no current chemical dependency or substance abuse exists that would effect provider's ability to adequately perform the professional duties for which provider is contracted.

K. Absence of a physical or mental health condition that would impair or would be likely to impair provider's ability to adequately perform the professional duties for which provider is contracted.

Meeting these Criteria and Standards does not automatically entitle an applicant to participate in the Plan.

II. Credentials Documentation

Before a participating provider will be reviewed for recredentialing, the following prerequisites must be met:

A. Completed questionnaire which includes copies of the following documents:

1. Valid, current and unrestricted licensure to practice in California.

2. Current DEA Certificate (if appropriate)

3. Evidence of current professional liability coverage which, meet or exceeds MHP minimum limits.

B. Signed release granting MHP access to records for credentialing purposes of any medical society, medical board, college of medicine, hospital, malpractice insurance carrier or any other institution, organization or entity which does or may maintain records concerning the applicant's practice of medicine.

C. Statement in writing by the applicant regarding:

1. Physical and mental health status.
2. Lack of impairment due to chemical dependency.
3. History of loss of license.
4. History of felony convictions.
5. History of limitation of privileges or disciplinary action.
6. Work history.
7. History of professional liability claims.

D. Signed attestation by applicant to the correctness and completeness of the application.

III. Committee Requirements

All of the following requirements must be met in order for the Credentialing Committee to consider continued participation of a provider.

A. Acceptable compliance with Criteria and Standards for provider participation.

B. The provider's recredentialing documentation is complete and prerequisites have been met.

C. Primary Source Verification of:

1. Valid, current and unrestricted California license to practice verified directly with the California State Licensing Board.
2. Valid current DEA certificate verified by viewing copy of DEA certificate. (if appropriate)
3. Clinical privileges in good standing at the hospital designated by the practitioner as the primary admitting participating facility.
4. Professional liability claims history.
5. Updates in board certification.
6. Review of Office of Inspector General / Exclusion List

D. Review of performance data from:

1. Member complaints.
2. Results of Quality Review.
3. Utilization Management.
4. Member Satisfaction Surveys.
5. On-site visit.

The recredentialing process may include an on-site visit to provider offices that results in documentation of a structured review of the site and medical record keeping

practices.

Note: See Also CMP 03:05 as to Ineligible Persons Screening Policy and Procedure

MADERA COUNTY
BEHAVIORAL HEALTH SERVICES

POLICY NO.: **CRD 05:00**

SUBJECT: **RECREDENTIALING CRITERIA**

POLICY:

Madera County Mental Health Plan (MHP) ensures that Medi-Cal beneficiaries receive services consistent with recognized community standards from qualified mental health practitioners. All providers must maintain an active license with the appropriate board and perform within MHP standards.

PURPOSE:

To provide criteria for monitoring providers to ensure standards set by the Mental Health Plan are being met.

PROCEDURE:

A. A provider will be subject to recredentialing every two years and according to the following MHP standards:

Standards		Measure
Ability to work with beneficiary and family/support persons in a professional, collaborative and c ulturally competent manner.		Per client satisfaction survey per, presences/absences of documented complaints/grievances in provider file.
To support the credentialing process of the MHP by establishing objective rating by clients of at least 80% satisfaction with services.		Per client satisfaction survey
Ability to meet the Quality Management, authorization, clinical, documentation, and administrative requirements of the MHP, and to work cooperatively with the staff who authorize and r e-authorize clinical services.		Per presence/absence of documented complaints in provider file. Per chart review as indicated by Quality Management procedures.

B. A renewal letter from the Behavioral Health Services Director will be sent every two years after the credentialing date to each provider who meets MHP standards. The renewal letter will include an Authorization For Release of Information and a Recredentialing Questionnaire to be returned to the Credentialing Coordinator. A list of attained CEUs by hours and topics

is requested but not mandated.

C. The provider will return the Recredentialing Questionnaire, a copy of his/her license, proof of malpractice insurance, and the Authorization for Release of Information sixty (60) days prior to the contract expiration date.

D. Upon receiving the information, the Credentialing Coordinator will present the provider's file to the Credentialing Committee for review at the regularly scheduled meeting, where recredentialing approval or non-approval will be determined.

   1. Files will be placed in pending when incomplete or when there are concerns about whether or not recredentialing standards have been met.

   2. Reasons for not renewing a provider's contract are outlined in Policy CRD: 04:00.

E. If a Network Provider has previously contracted with the MHP and was in good standing at resignation, he/she may reapply. A recredentialing package, a copy of current license, malpractice insurance verification and other verification is required. If Network Provider was not in good standing at resignation, a full application must be made subject to the criteria outlined in CRD: 04:00.

MADERA COUNTY MENTAL HEALTH PLAN
Bi-Annual Recredentialing Questionnaire

INSTRUCTIONS: *Please complete all sections; enter "N/A" if not applicable. Please print or type information.*

A. IDENTIFYING INFORMATION

Name: ______________________ ________ ______________________
First MI Last

SSN: _______ – ______ – _____________ Date of Birth: ______________________

Office Location(s): Please attach additional sheets if necessary.

Office #1 (Primary)

Address: ______________________ City: ________________ Zip: ____________

Phone: (______) ________________ Fax: (_____) ________________

Office # 2

Address: ______________________ City: ________________ Zip: ____________

Phone: (______) ________________ Fax: (_____) ________________

E-Mail Address (Optional) ______________________________________

Type of Practice (please provide legal name of practice):

☐ Sole Proprietor – Name: ______________________________________

☐ Group – Group Name: ______________________ Address: ________________

Please provide the names and disciplines of other providers in the group:

____

____

☐ Corporation – Corp Name: ______________________ Address: ________________

B. CONTINUING EDUCATION (for past 2 years; for Psychologists, LCSWs and LMFTs only)

Course Title	Date Completed

C. LICENSE INFORMATION – Please attach a copy of all license(s)

State	License Number	Type of License	Expiration Date
Complete only if applicable	Medi-Cal Provider #:		
	Medicare UPIN:	NPI#:	
	DEA Number:	ECFMG#/Date:	
	DEA Expiration Date:	Taxonomy:	

D. BOARD CERTIFICATION

Name of Board	Certification Date	Expiration Date (if applicable)

E. HOSPITAL PRIVILEGES – Current and Previous

Hospital Name	Address, City and State	Appointment Date	Withdrawal Date (if applicable)

F. LICENSE INFORMATION – Please attach a copy of all license(s)

Please answer all of the following questions #1-11. If you answer "Yes" to any question, please provide a detailed explanation on a separate page. Explanation should include dates, details of the incident, final outcome, current disposition, etc. In the past two years:

1. Yes ☐ No ☐ Have there been any disciplinary actions or investigations against you by any state licensing board?
   Yes ☐ No ☐ Are there any actions or investigations in process?
   Yes ☐ No ☐ Have you voluntarily surrendered your medical/clinical license?
2. Yes ☐ No ☐ Has your DEA registration ever been denied, suspended, revoked or limited in any other manner?
   Yes ☐ No ☐ Are there any actions or investigations in process?
   Yes ☐ No ☐ Have you voluntarily surrendered your DEA registration?
3. Yes ☐ No ☐ Has your professional liability insurance coverage ever been canceled, limited, denied or non-renewed?
   Yes ☐ No ☐ Any malpractice claims filed against you?
4. Yes ☐ No ☐ Have you privileges at any hospital ever been denied, suspended, reduced, revoked or put on probation?
   Yes ☐ No ☐ Are any investigations in process?
   Yes ☐ No ☐ Have you resigned from any hospitals?
5. Yes ☐ No ☐ Have you ever been investigated, suspended, sanctioned or otherwise restricted from participating in a federal or State health insurance?
6. Yes ☐ No ☐ Have there been any criminal proceedings against you including, but not limited to, gross misconduct, a felony or a crime of moral turpitude?
7. Yes ☐ No ☐ Do you suffer from any illness, injury or health condition (physical or mental) which limits or impairs your ability to safely provide medical services? This includes medication that may affect either your clinical judgment or motor skills.
8. Yes ☐ No ☐ Have you ever undergone treatment for alcohol or drug abuse dependency?
9. Have you ever had any of the following:
   . Yes ☐ No ☐ Lawsuits dismissed, dropped or pending
   Yes ☐ No ☐ Settlements including settled and dismissed with prejudice
   Yes ☐ No ☐ Judgments
   Yes ☐ No ☐ Reprimands or disciplinary action
   Yes ☐ No ☐ Other
10. Yes ☐ No ☐ To your knowledge, has any information pertaining to you ever been reported to the National Practitioner Data Bank?
11. Yes ☐ No ☐ Have you voluntarily quit or involuntarily been terminated from any Managed Care plan?

G. AVAILABILITY / ACCESSIBILITY

Currently available for new clients? Yes ☐ No ☐

Ethnic, Racial & Culture Specific Specialties: ______________________

Days Available: Mon ☐ Tues ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun ☐

Hours available: ________ ________ ________ ________ ________ ________ ________

List languages spoken in addition to English: ______________________

H. POPULATION & SERVICE AREAS

Population served: Children 5 & under: ☐ Children 6 to 12: ☐ Adolescents: ☐ Adults: ☐ Older Adults: ☐

Service area(s) offered: Individual: ☐ Family: ☐ Group: ☐ Medications: ☐ Psych Testing: ☐

Inpatient: ☐ Other (specify): ☐

I. Signature

Please read this statement before signing:

Information provided on this questionnaire may be verified. My signature certifies that all the information on this questionnaire is true, correct and complete. I understand and agree that any misstatements or omissions of material facts herein may cause forfeiture on my part of my right to continued participation as a provider with the Madera County Mental Health Plan.

Signature: ______________________ Date:

J. PAYMENT INFORMATION

If I am recredentialed to continue being a provider with the Madera County Mental Health Plan, payments for services provided should be made to me as follows:

Make checks payable to: ______________________

Tax ID: ______________________

Send checks to the following:

Address: ______________________

City: ______________________ State: ________ Zip: ________

MADERA COUNTY IS AN EQUAL OPPORTUNITY, DISABILITIES, AFFIRMATIVE ACTION ORGANIZATION THAT DOES NOT DISCRIMINATE IN REGARDS TO AGE, GENDER, COLOR, RACE, RELIGION, NATIONAL ORIGIN, HANDICAP OR SEXUAL ORIENTATION.

AUTHORIZATION TO RELEASE CREDENTIALING INFORMATION

I, ______________________________ give my permission for ____________________
(print name) (County Releasing Information)

County Mental Health Plan to release a copy of my Credentialing information to Madera County Mental Health Plan for my credentialing/application process.

During such time as this application is being processed, I agree to update the application should there be any changes in the information provided which may affect the application or its outcome.

Name (print): ____________________________ License: ______________________

Signature: ______________________________ Date: ________________________

Address: ____

MADERA COUNTY
BEHAVIORAL HEALTH SERVICES

POLICY NO.: **CRD 06:00**

SUBJECT: **BEHAVIORAL HEALTH SERVICES (BHS) AND ORGANIZATIONAL PROVIDER CREDENTIALING OF LICENSED PERSONNEL**

<u>POLICY</u>:

All providers must maintain an active license with the appropriate board and perform within Mental Health Plan (MHP) standards.

<u>PURPOSE</u>:

To ensure staff are appropriately licensed or certified to perform assigned duties.

<u>PROCEDURE</u>:

I. Behavioral Health Services (BHS) Staff/Contractors

   A. A list of all licensed staff will be made by Support Services personnel.

   B. Support Services personnel will review, on a monthly basis, licenses of all BHS staff/contractors whose license will expire within 60 days.

   C. Licensed BHS staff/contractors and registered interns will bring a copy of their new/renewed license or registration to Support Services personnel.

   D. Support Services personnel will review the list and notify the BHS Director of any lapsed licenses or registrations.

   E. A copy of the license/registration will be stored in a locked cabinet in the BHS Personnel Department.

II. Organizational Provider Staff

   A. MHP requires all organizational providers to credential their professional staff. Education and experience will be verified for all direct services staff.

   B. Organizational Provider Administration will notify designated staff of their license expiration and will maintain a current list.

   C. Have accounting/fiscal practices that meet the standards of the State Department of Mental Health.

   D. Have a head of service meeting Title IX requirements.

   E. Licensed staff and registered interns will bring a copy of their new/renewed

license or registration to the Administration of the Organizational Provider.

1. The Organizational Provider Administration will provide BHS with a list of licensed/registered staff and the status of their license/registration on a monthly basis.
2. MHP will review the list and notify the Organization Provider Administration of any lapsed licenses or registrations.
3. The list of licensed organizational provider staff will be maintained in a locked cabinet in the MHP office.

MADERA COUNTY
BEHAVIORAL HEALTH SERVICES

POLICY NO.: **CRD 07:00**

SUBJECT: **TERMINATION OF PRIVILEGES**

POLICY:

Madera County Behavioral Health Services (BHS) staff or anyone who contracts with BHS will maintain compliance with all criteria as a condition of continued participation.

PURPOSE:

To ensure that BHS mental health professionals and contractors provide continued competent health services to Madera County Medi-Cal beneficiaries.

PROCEDURE:

I. Criteria for Termination of Full Privileges

A. The criteria for terminating privileges may include, but is not limited to, the following factors related to job performance, professional integrity or contractual provisions.

1. Submission of inaccurate or misleading information on the application or failure to disclose relevant information.
2. Violating the BHS Code of Ethical Conduct.
3. Failure to meet compliance with the Board of Behavioral Sciences (BBS), General Services Administration (GSA) List of Parties Excluded from Federal Procurement and Nonprocurement Programs and the HHS/OIG Cumulative Sanction Report, the Medical Board of California and the Medi-Cal Suspended and Ineligible List-California Department of Health Care Services.
4. Failure to obtain required training for licensure.
5. MHP’s inability to complete a credentialing process due to the applicant’s failure to provide relevant information or necessary release.
6. A provider not adhering to all contract terms, including, but not limited to, access and coverage requirements during the participation period.
7. Current or past loss of significant restrictions to professional license.
8. Current or past loss or significant restrictions to Drug Enforcement Administration (DEA), if appropriate.
9. Current or past loss or significant restriction to hospital privileges.

10. Criminal record affecting professional practice.
11. Current or past sanction by Medicare/Medicaid.
12. Current chemical dependency or substance abuse.
13. History of malpractice claims.
14. Quality problems as reported by licensing boards, Federation of State Medical Boards or prior work/training settings.
15. Quality problems identified during the participation period, as determined by the Quality Management Program.
16. Failure to follow MHP's policies, procedures and documentation requirements.
17. Current physical or mental health problem(s) which significantly impair provider's ability to perform professional contracted duties.
18. Member service issues or complaints identified and documented during the participation period.
19. Utilization issues identified and documented during the participation period.
20. MHP, at its sole discretion, has the right to deny full privileges based on plan and/or membership needs.

II. Recommendation for Termination of Privileges

The Behavioral Health Services Director shall be notified of any instances involving a provider who meets one or more of the criteria for termination of full privileges (see section I.A.1-20 of this policy for criteria for termination).

A. Process

1. The Behavioral Health Services Director will review the information presented, and if appropriate, convene with the Credentialing Committee to conduct a formal investigation/evaluation of the facts.
2. Following an i nvestigation, the Credentialing Committee will make a recommendation to the Behavioral Health Services Director.
3. The Behavioral Health Services Director will review the Committee's findings and make a decision.
    a. A recommendation for termination of privileges will be closed if the Director decides to continue credentialing and allow full privileges.
4. If the Behavioral Health Services Director decides to terminate privileges for cause, the Director will provide a written notice to the provider within twenty-one (21) days from the date recommendations were received by the Committee.

III. Appealing a Decision for Termination of Privileges

The information used to terminate privileges shall be made available to the provider and s/he shall receive the opportunity to provide additional information that may affect MHP's decision.

A. Process

1. The provider must submit a written request to appeal a decision to terminate privileges to the Behavioral Health Services Director within thirty (30) days following posting of the written decision.
2. A hearing will be scheduled with the Credentialing Committee within fifteen (15) days of receipt of an appeal, which will allow the provider an opportunity to discuss with the Credentialing Committee the reasons for termination of privileges and present any statements, documents or other materials the provider feels should be considered by the Committee.
3. After a formal meeting, the Credentialing Committee will provide a recommendation to the Behavioral Health Services Director within fifteen (15) days from the date of the hearing.
4. The Behavioral Health Services Director will give written notice to the provider on the final decision within twenty-one (21) days from the date Committee recommendations were received
5. If the Director decides to terminate privilege for cause, contract procedures for termination of privileges will be initiated.

B. The contract procedures to terminate will be initiated if the provider does not appeal the decision within thirty (30) days after the written decision is posted.

C. To protect the quality of care provided to Medi-Cal beneficiaries, a termination of privileges may be made effective immediately by MHP and/or the Credentialing Committee.

ATTACHMENT U

Advance

Medical

Directive

MHP 37.00

MADERA COUNTY
BEHAVIORAL HEALTH SERVICES

POLICY NO.: **MHP 37:00**

SUBJECT: **ADVANCE MEDICAL DIRECTIVES**

POLICY:

All adult Medi-Cal beneficiaries will receive information concerning their rights under California State law regarding Advance Medical Directives.

PURPOSE:

To ensure adult Medi-Cal beneficiaries served by Madera County Mental Health Plan (MHP) are provided with information concerning their rights under California state law regarding Advance Directives (Title 42, Code of Federal regulations, section 422.128, 438.6(i)(1), (3) and (4) and 417.436(d)).

PROCEDURES:

A. MHP staff and contracted providers shall provide written information regarding Advance Medical Directives when they have their first face-to-face service contact with the beneficiary and, thereafter, upon a request from a beneficiary.

B. Informing material regarding Advance Medical Directives shall be maintained in compliance with existing California state law and be u pdated to reflect changes in state law within 90 days of the implementation of a change.

C. In the event a Medi-Cal beneficiary presents a completed, appropriately witnessed, signed and executed Advance Medical Directive to Madera County MHP staff or contracted providers of the MHP, the Advance Medical Directive shall be placed in the beneficiary's mental health medical record and t he presence of the Advance Medical Directive shall be noted prominently in the chart.

D. Madera County MHP staff or contracted providers of the MHP will respect the implementation of the beneficiary's rights to make decisions concerning health care*, including the right to accept or refuse treatment and the right to formulate, at the individual's option, advance directive.

   * Note: Section 4615 California Probate Code: "Health Care" means any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a patient's physical or mental condition.

E. Madera County MHP staff or contracted providers of the MHP will ensure that beneficiaries are not discriminated against based on whether or not they execute an advance directive.

F. Madera County MHP will provide for the education of staff concerning its policies and procedures on advance directive.

G. Madera County MHP Staff are not to assist in filling out advance directives for beneficiaries.

H. Madera County MHP will inform beneficiaries that complaints concerning non-compliance with the advance directive may be f iled with the state survey and certification agency (DHS, Licensing and Certification Division at 1-800-236-9747).

Legal Reference:

1. California Probate Code Section 4600 - 4643
2. California Probate Code Section 4677
3. California Probate Code Section 4678
4. California Probate Code Section 4686
5. California Probate Code Section 4689
6. California Probate Code Section 4695
7. California Probate Code Section 4730 - 4732
8. California Probate Code Section 4740
9. California Probate Code Section 4742

MADERA COUNTY BEHAVIORAL HEALTH SERVICES

ADVANCE DIRECTIVES
DOCUMENTATION OF CHANGE

COPY OF "YOUR RIGHT TO MAKE DECISIONS
ABOUT MEDICAL TREATMENT" GIVEN TO CLIENT: ______________________
DATE

ORIGINAL ADVANCE DIRECTIVES COMPLETED: ______________________
DATE

Any changes to client's advance directives must be documented on a progress note. Please document on this form the date of the progress note that contains the documented change.

DATE OF PROGRESS NOTE	COMMENTS	SIGNATURE

MADERA COUNTY BEHAVIORAL HEALTH SERVICES

Your Right To Make Decisions About Medical Treatment

This brochure explains your right to make healthcare decisions and how you can plan now for your medical care if you are unable to speak for yourself in the future. A federal law requires us to give you this information. We hope this information will help increase your control over your medical treatment.

Who decides about my treatment?

Your doctors will give you information and advice about treatment. You have the right to choose. You can say "Yes" to treatments you want. You can say "No" to any treatment that you don't want - even if the treatment might keep you alive longer.

How do I know what I want?

Your doctor must tell you about your medical condition and about what different treatments and pain management alternatives can do for you. Many treatments have "side effects". Your doctor must offer you information about problems that medical treatment is likely to cause you. Often, more than one treatment might help you-and people have different ideas about which is best. Your doctor can tell you which treatments are available to you, but your doctor can't choose for you. That choice is yours to make and depends on what is important to you.

Can other people help with my decisions?

Yes. Patients often turn to their relatives and close friends for help in making medical decisions. These people can help you think about the choices you face. You can ask the doctors and nurses to talk with your relatives and friends. They can ask the doctors and nurses questions for you.

Can I choose a relative or friend to make healthcare decisions for me?

Yes. You may tell your doctor that you want someone else to make healthcare decisions for you. Ask the doctor to list that person as your healthcare "surrogate" in your medical record. The surrogate's control over your medical decisions is effective only during treatment for your current illness or injury or, if you are in a medical facility, until you leave the facility.

What if I become too sick to make my own healthcare decisions?

If you haven't named a surrogate, your doctor will ask your closest available relative or friend to help decide what is best for you. Most of the time that works. But sometimes everyone doesn't agree about what to do. That's why it is helpful if you can say in advance what you want to happen if you cannot speak for yourself.

Do I have to wait until I am sick to express my wishes about health care?

No. In fact, it is better to choose before you get very sick or have to go into a hospital, nursing home, or other healthcare facility. You can use an Advance Health Care Directive to say who you want to speak for you and what kind of treatments you want. These documents are called 'advance' because you prepare one before healthcare decisions need to be made. They are called 'directives' because they state who will speak on your behalf and what should be done. In California, the part of an advance directive you can use to appoint an agent to make healthcare decisions is called a Power of Attorney For Health Care. The part where you can express what you want done is called an Individual Health Care Instruction.

Who can make an advance directive?

You can if you are 18 years or older and are capable of making your own medical decisions. You do not need a lawyer.

Who can I name as my agent?

You can choose an adult relative or any other person you trust to speak for you when medical decisions must be made.

When does my agent begin making my medical decisions?

Usually, a healthcare agent will make decisions only after you lose the ability to make them yourself. But, if you wish, you can state in the Power of Attorney for Health Care that you want the agent to begin making decisions immediately.

How does my agent know what I would want?

After you choose your agent, talk to that person about what you want. Sometimes treatment decisions are hard to make, and it truly helps if your agent knows what you want. You can also write your wishes down in your advance directive.

What if I don't want to name an agent?

You can still write out your wishes in your advance directive, without naming an agent. You can say that you want to have your life continued as long as possible. Or you can say that you would not want treatment to continue your life. Also, you can express your wishes about the use of pain relief or any other type of medical treatment. Even if you have not filled out a written Individual Health Care Instruction, you can discuss your wishes with your doctor, and ask your doctor to list those wishes in your medical record. Or you can discuss your wishes with your family members or friends. But it will probably be easier to follow your wishes if you write them down.

What if I change my mind?

You can change or cancel your advance directive at any time as long as you can communicate your wishes. To change the person you want to make your healthcare decisions, you must sign a statement or tell the doctor in charge of your care.

What happens when someone else makes decisions about my treatment?

The same rules apply to anyone who makes healthcare decisions on your behalf - a healthcare agent, a surrogate whose name you gave to your doctor, or a person appointed by a court to make decisions for you. All are required to follow your Health Care Instructions or, if none, your general wishes about treatment, including stopping treatment. If your treatment wishes are not known, the surrogate must try to determine what is in your best interest. The people providing your health care must follow the decisions of your agent or surrogate unless a requested treatment would be bad medical practice or ineffective in helping you. If this causes disagreement that cannot be worked out, the provider must make a reasonable effort to find another healthcare provider to take over your treatment.

Will I still be treated if I don't make an advance directive?

Absolutely. You will still get medical treatment. We just want you to know that if you become too sick to make decisions, someone else will have to make them for you. Remember that: A Power of Attorney For Health Care lets you name an agent to make decisions for you. Your agent can make most medical decisions - not just those about life sustaining treatment - when you can't speak for yourself. You can also let your agent make decisions earlier, if you wish. You can create an Individual Healthcare Instruction by writing down your wishes about health care or by talking with your doctor and asking the doctor to record your wishes in your medical file. If you know when you would or would not want certain types of treatment, an Instruction provides a good way to make your wishes clear to your doctor and to anyone else who may be involved in deciding about treatment on your behalf. These two types of Advance Healthcare Directives may be used together or separately.

How can I get more information about making an advance directive?

Ask your doctor, nurse, social worker, or healthcare provider to get more information for you. You can have a lawyer write an advance directive for you, or you can complete an advance directive by filling in the blanks on a form.

Complaints regarding non-compliance with Advance Directive requirements may be filed with California Department of Health Services Licensing and Certification by calling 1-800-236-9747 or by mail at P.O. Box 997413, Sacramento, CA 95899-1413.

SERVICIOS MÉDICOS DEL COMPORTAMIENTO del CONDADO de MADERA

Su Derecho de Hacer Las Decisiones Sobre el Tratamiento Médico

Este folleto explica su derecho de tomar decisiones de su cuidado de salud y cómo usted puede ahora planear para su asistencia médica si usted no puede hablar por si mismo en el futuro. Una ley federal nos requiere darle esta información. Esperamos que esta información ayude a aumentar su control sobre su tratamiento médico.

¿Quién decide sobre mi tratamiento?

Sus doctores le darán la información y el consejo sobre el tratamiento. Usted tiene el derecho de elegir. Usted puede decir "sí" a los tratamientos que usted desee. Usted puede decir "no" a cualquier tratamiento que usted no desee - incluso si el tratamiento pudo guardarlo vivo más largo.

¿Cómo sé lo que deseo?

Su doctor debe decirle sobre su condición médica y sobre qué diversos tratamientos y alternativas de la gerencia del dolor pueden hacer para usted. Muchos tratamientos tienen "efectos secundarios". Su doctor debe ofrecerle la información sobre problemas que el tratamiento médico puede causarle. A menudo, más de un tratamiento puede ayudarle - y gente tiene diversas ideas sobre las cuales es la mejor. Su doctor puede decirle qué tratamientos están disponibles para usted, solamente su doctor no puede elegir para usted. Esa opción es la suya para hacer y depende de cuál es importante para usted.

¿Puede otra gente ayudar con mis decisiones?

Sí. Los pacientes dan vuelta a sus parientes y a menudo a amigos cercos para la ayuda en tomar decisiones médicas. Esta gente puede ayudarle a pensar de las opciones que usted enfrenta. Usted puede pedir que los doctores y las enfermeras hablen con sus parientes y amigos. Pueden preguntar a los doctores y enfermeras las preguntas para usted.

¿Puedo elegir a un pariente o a un amigo para tomar las decisiones del cuidado medico para mí?

Sí. Usted puede decir a su doctor que usted quisiera que otro tome las decisiones del cuidado medico para usted. Pida que el doctor enumere a esa persona como su "sustituto" de cuidado medico en su expediente médico. El control del sustituto sobre sus decisiones médicas es eficaz solamente durante el tratamiento para su enfermedad o lesión actual o, si usted está en una facilidad médica, hasta que usted deje la facilidad.

¿Qué si llego a estar demasiado enfermo para tomar mis propias decisiones del cuidado medico?

Si usted no ha nombrado un sustituto, su doctor preguntará a su pariente disponible más cercano o el amigo por ayuda a decidir que es lo mejor para usted. La mayoría del tiempo eso trabaja. Pero a veces todos no están de acuerdo sobre que hacer. Ése es porqué es provechoso si usted puede decir por adelantado lo que usted desea que suceda si usted no puede hablar para si.

¿Tengo que esperar hasta que este enfermo para expresar mis deseos sobre cuidado médico?

No. En hecho, es mejor elegir antes de que usted se ponga muy enfermo o tenga que entrar al hospital, la clínica de reposo, o a otra facilidad de cuidado medical. Usted puede utilizar un Directorio Anticipado del Cuidado Médico para decir quién usted desea que hable por usted y qué clase de tratamientos usted desea. Estos documentos se llaman 'anticipados' porque usted prepara uno antes de que las decisiones de cuidado medico necesiten ser tomadas. Se llaman los 'directorios' porque indican quién hablarán en su favor y qué debe ser hecho. En California, la parte de un directorio anticipado que usted puede utilizar para designar a un agente para tomar decisiones de cuidado de salud se llama un Poder de Abogado Para el Cuidado Médico. La pieza donde usted puede expresar lo que usted desea hecho se llama una Instrucción Individual de Cuidado Médico.

¿Quién puede hacer un directorio anticipado?

Usted puede si usted tiene 18 años o más y es capaz de tomar sus propias decisiones médicas. Usted no necesita un abogado.

¿A quién puedo nombrar como mi agente?

Usted puede elegir a un adulto relativo o a cualquier otra persona que usted confíe para hablar para usted cuando las decisiones médicas deben ser tomadas**.**

¿Cuándo comienza mi agente a tomar mis decisiones médicas?

Generalmente, un agente de cuidado medico tomará decisiones solamente después que usted pierda la capacidad de hacerlas usted mismo. Pero, si usted desea, usted puede indicar en el Poder de Abogado para el Cuidado Médico que usted quisiera que el agente comience a tomar decisiones inmediatamente.

¿Cómo sabe mi agente lo que desearía?

Después de que usted elija su agente, hable con esa persona sobre lo que usted desea. Las decisiones del tratamiento son a veces duras de hacer, y en verdad ayuda si su agente sabe lo que usted desea. Usted puede también escribir sus deseos en su Directorio Anticipado.

¿Qué si no deseo nombrar un agente?

Usted puede poner sus deseos en escrito en su directorio anticipado, sin el nombramiento de un agente. Usted puede decir que usted desea hacer su vida que continué tan largo como sea posible. O usted puede decir que usted no quisiera que el tratamiento continuara su vida. También, usted puede expresar sus deseos sobre el uso de la relevación del dolor o de cualquier otro tipo de tratamiento médico. Incluso si usted no ha completado una Instrucción Individual escrita de Cuidado Médico, usted puede discutir sus deseos con su doctor, y pida que su doctor enumere esos deseos en su expediente médico. O usted puede discutir sus deseos con sus miembros o amigos de la familia. Pero será probablemente más fácil seguir sus deseos si usted los escribe.

¿Qué si cambio mi mente?

Usted puede cambiar o cancelar su directorio anticipado en cualquier momento mientras usted puede comunicar sus deseos. Para cambiar a la persona que usted desea tomar sus decisiones de cuidado medico, usted debe firmar una declaración o decirle al doctor a cargo de su cuidado.

¿Qué sucede cuando algún otro toma decisiones sobre mi tratamiento?

Las mismas reglas se aplican a cualquier persona que tome decisiones de su cuidado medico en su favor - un agente del cuidado medico, un sustituto que nombre usted dio a su doctor, o a una persona designada por una corte para tomar las decisiones para usted. Todos son requeridos a seguir sus instrucciones del cuidado médico o, si ninguno, su deseo general sobre el tratamiento, incluyendo parar el tratamiento. Si sus deseos del tratamiento no se saben, el sustituto debe intentar de determinar cuál es de su mejor interés. La gente que proporciona su cuidado médico debe seguir las decisiones de su agente o sustituir a menos que un tratamiento solicitado fuera mal práctica médica o ineficaz en ayudarle. Si esto causa el desacuerdo que no puede ser resuelto, el proveedor debe hacer un esfuerzo razonable de encontrar otro proveedor de cuidado medico para asumir el control de su tratamiento.

¿Me tratarán sin embargo si no hago un directorio anticipado?

Absolutamente. Usted todavía conseguirá el tratamiento médico. Apenas quisiéramos que usted supiera que si usted llega a ser demasiado enfermo para tomar decisiones, alguien tendrá que hacerlas para usted. Recuerde eso: Un Poder de Abogado Para el Cuidado Médico le deja nombrar a un agente para tomar las decisiones para usted. Su agente puede tomar la mayoría de las decisiones médicas - no solamente ésas sobre el tratamiento que sostiene de la vida - cuando usted no puede hablar por si mismo. Usted puede también dejar que su agente tome decisiones anteriores, si usted desea. Usted puede crear una Instrucción Individual de Cuidado Medico anotando sus deseos sobre cuidado médico o hablando con su doctor y pidiendo que el doctor registre sus deseos en su archivo médico. Si usted sabe cuándo usted o no desearía ciertos tipos de tratamiento, una Instrucción proporciona una buena manera de hacer sus deseos claros a su doctor y a cualquier otra persona quién puede estar implicada en decidir sobre el tratamiento en su favor. Estos dos tipos de Directorios Anticipados de cuidado medico se pueden utilizar juntos o por separado.

¿Cómo puedo conseguir más información sobre la fabricación de un directorio anticipado?

Pida que su doctor, enfermera, trabajador social, o proveedor de cuidado medico consigan más información para usted. Usted puede hacer que un abogado escriba un Directorio Anticipado para usted, o usted puede terminar un Directorio anticipado completando los espacios en blanco en una forma.

Las quejas con respecto a incumplimiento con los requisitos Directivos Anticipados se pueden archivar con el Departamento de California de los Servicios Médicos de Licencias y Certificación llamando 1-800-236-9747 o por correo al P.O. Box 997413, Sacramento, CA 95899-1413.