Managed Care Manual

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1. INTRODUCTION

2. BACKGROUND

Until 1995, California operated two distinct Medi-Cal systems for mental health services:

A public provider Medi-Cal system (Short-Doyle/Medi-Cal) which was implemented in 1966 and, a private provider Medi-Cal system (Fee-for-Service Medi-Cal) which was implemented in 1972.

Fee-for-Service Medi-Cal (FFS/MC)
In the FFS/MC system, private hospitals and practitioners provided mental health services to Medi-Cal recipients and billed the State directly. The need for outpatient service was determined by the provider of service - a licensed psychologist or psychiatrist. The need for inpatient services was determined by the State Department of Health Services.

Short-Doyle Medi-Cal
In the Short-Doyle Medi-Cal system, State funds were distributed to counties to provide mental health services for Medi-Cal eligible persons who met program requirements. The county programs provided a broad range of services including medications, rehabilitation, case management and inpatient care.

Operating dual systems which were separately managed but had overlapping services created inefficiencies in administration and service delivery. It also impeded development of a coordinated system of care for individuals who need public mental health services.

In order to address these inefficiencies, AB 757 (1994) authorized the transfer of state funding for FFS/MC specialty mental health services from the Department of Health Services (DHS) to the Department of Mental Health (DMH). Effective January 1, 1995, the responsibility and funding for psychiatric inpatient hospital services were transferred to participating counties.

On April 1, 1998, DMH transferred the funds and the responsibility for authorization and funding of FFS/MC specialty mental health professional and nursing facility services to counties that chose to participate in this program. Those counties choosing to participate were designated as the Mental Health Plan (MHP). The merging of these two Medi-Cal systems is known as Specialty Mental Health Consolidation.

3. MISSION OF THE MADERA COUNTY MENTAL HEALTH PLAN

To provide high quality, cost effective, and culturally proficient mental health care to all Medi-Cal beneficiaries who require specialty mental health services.

4. VALUES OF MADERA COUNTY MENTAL HEALTH PLAN

A. Clients and family members will be treated respectfully and encouraged to participate in treatment determination.

B. Initial contact, assessment and assignment will occur in a timely manner.

C. Assignment for services will take into consideration the following: geographical needs, age, ethnicity, language, culture, clinician expertise, and client/family preference. Clients and/or family members will not be required to provide their own interpreters.

D. Individuals who do not meet medical necessity criteria or financial eligibility will be provided with information regarding support groups, educational programs, social service programs, substance abuse treatment services, housing assistance, and other community services. When appropriate, they will be referred to primary care providers for treatment.

E. Medi-Cal beneficiaries who are denied specialty mental health services will be informed of the appeal process available to them.

5. DEFINITIONS

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

B. BENEFICIARY
A Madera County Medi-Cal recipient.

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

D. CONSUMER ACCESS LINE 1(888)275-9779, (559) 673-3508 or TTY (800) 735-2929
A Statewide toll-free telephone line with linguistic capability is available to consumers/beneficiaries 24 hours, 7 DAYS A WEEK. The 24-hour line provides information on how to access specialty mental health services, including services needed to treat a consumer's urgent condition, and how to use the consumer problem resolution and fair hearing process.

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

F. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)

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

G. GROUP PROVIDER

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

H. MADERA COUNTY MEDI-CAL BENEFICIARIES

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

I. MADERA COUNTY MENTAL HEALTH PLAN (MHP)

The county organization responsible for the mental health needs of all Medi-Cal-eligible residents of Madera County.

J. MEDICAL NECESSITY

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

K NETWORK PROVIDER

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

L ORGANIZATIONAL PROVIDER (Org Provider)

Organizational provider means a provider of specialty mental health services other than psychiatric inpatient hospital services or psychiatric nursing facility services that ***provides the services to beneficiaries through employed or contracting licensed mental health or waivered/registered professionals and other staff.*** The MHP is an organizational provider when specialty mental health services are provided to beneficiaries by employees of the MHP.
Note: Authority: Section 14680, Welfare and Institutions Code
Reference: Sections 5777 and 14684, Welfare and Institutions Code.

M PRIMARY CARE PHYSICIAN (PCP)

A physician responsible for supervising, coordinating, and providing initial and

primary care to beneficiaries. Other responsibilities include initiating referrals for specialist care and maintaining the continuity of beneficiary's care.

N. PUBLIC MANAGED CARE

A system which is responsible for providing clinical services and managing fiscal risk of its members. It serves public sector clients with public funds and with public accountability.

O. QUALITY MANAGEMENT CLINICIAN/COORDINATOR

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

P SPECIALTY MENTAL HEALTH SERVICES

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

Q. URGENT CONDITION

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

6. PROVIDER NETWORK

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

Licensed Network Providers

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

Wraparound (SB163) Organizational Providers

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

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

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

Tier 2 Target Population
Children eligible for Tier 2 Wraparound services must; Have an open DCFS case (Court or Voluntary) Qualify for Early and Periodic Screening Diagnostic and Treatment Program (EPSDT) Have an urgent and/or intensive mental health need which causes impairment at school, home and/or in the community.

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

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

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

All Providers must offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid fee-for-service, if the provider serves only Medicaid beneficiaries. There should be no discrimination against Medi-Cal beneficiaries, e.g., appointment times limited to specific hours of the day/week compared to other clients with other funding

sources. Network Providers may not discriminate on the basis of race/ethnicity, color, national origin, sexual orientation, sex, disability, veteran status, or age.

7. TARGET POPULATION

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

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

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

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

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

8. TREATMENT AUTHORIZATION/OUTPATIENT SERVICES

A. SCREENING AND INITIAL AUTHORIZATION

1. Requests for outpatient mental health services may originate with a community agency, a primary care physician, a specialty mental health provider or with the beneficiary/family/legal guardian. All requests for services excluding crisis after hours services and wraparound services must be screened through the Screening & Disposition process by calling (559) 673-3508, 1(888) 275-9779 or TTY 1 (800) 735-2929

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

3. If the beneficiary is determined to be eligible for mental health services, s/he has the right to request a specific county contracted mental health

provider. The MHP reserves the right to determine the most appropriate mental health provider.

4. All planned services to beneficiaries **MUST BE PRE-AUTHORIZED** by the MHP.

   a. Services provided to beneficiaries without authorization will not be reimbursed.

   b. The authorization period ends when the allowed visits have been expended or the authorization period, within one day less than 30 days from the date of the Screen and Disposition (S & D) (Attachment L2).

5. The beneficiary's choice, past history of treatment, and ability to meet special needs will be carefully considered in selecting a Provider. However, the MHP reserves the final right of assignment of the client to a service provider.

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

7. The MHP clinician will contact the Provider whom the Medi-Cal beneficiary selects to verify s/he is accepting new Medi-Cal clients.

8. The MHP will then send an authorization for two (2) assessment visits plus one (1) session to the contracting provider over a period of two months, less one day from the date of the S&D.

   a. Providers will be required to schedule an initial visit with an authorized beneficiary within five (5) working days of the beneficiary's request for an appointment unless the beneficiary requests a later date.

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

B. ASSESSMENT DOCUMENTATION STANDARDS/TREATMENT PLAN AUTHORIZATION.

A comprehensive mental health assessment (Attachment D) includes the following areas:

1. Relevant physical health conditions reported by the client will be prominently identified and updated as appropriate.

2. Presenting problems and relevant conditions affecting the client's physical health and mental health status will be documented. For example: living situation, daily activities, social support.

3. Documentation will describe client strengths in achieving client plan goals.

4. Special status situations that present a risk to client or others will be prominently documented and updated as appropriate.

5. Documentation will include medications that have been prescribed by mental health plan physicians and primary care physicians (PCP), dosages of each medication, dates of initial prescriptions and refills, and documentation of informed consent for medications.

6. Client self report of allergies and adverse reactions to medications, or lack of known allergies/sensitivities will be clearly documented.

7. A mental health history will be documented, including previous treatment dates, providers, therapeutic interventions and responses, sources of clinical data, relevant family information, and results of relevant lab tests and consultation reports.

8. For children and adolescents, prenatal and perinatal events and complete developmental history is to be included.

9. Past and present use of tobacco, alcohol, and caffeine, as well as illicit, prescribed and over-the-counter drugs must be documented.

10. A relevant mental status examination is to be completed.

11. A five axis diagnosis from the most current Diagnostic and Statistical Manual of Mental Disorders (DSM) will be documented, consistent with the presenting problems, history, mental status evaluation and/or other assessment data.

12. Client's signature verifying client's/guardian's participation in treatment planning and process.

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

    a. The MHP will review the assessment, treatment plan, and request for additional services to help insure that medical necessity is met and that appropriate treatment is being provided.

    b. The MHP may authorize up to six months and a combination of

individual, family, TBS, Wraparound and group services.

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

C. TREATMENT PLAN (Attachment B3 or B4)

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

   a. Treatment goals
   b. Treatment objectives
   c. Treatment modalities
   d. Treatment interventions
   e. Projected target dates for completion of treatment
   f. Cultural issues
   g. Client/Guardian strengths and commitment to participate in treatment
   h. Justification for extension of services

2. All Wraparound Treatment Plans must include the Child and Adolescent Needs and Strengths (CANS) outcome measures.

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

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

D. REAUTHORIZATION/UPDATED ANNUAL ASSESSMENT STANDARDS/ TREATMENT PLAN (Attachment D1,D2, D3 or D4, D6)

1. The Reauthorization/annual updated assessment will include:
   a. Symptoms
   b. Current psychotropic medication
   c. Five axis DSM IV diagnoses
   d. Impairments
   e. Progress toward previous treatment goals

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

a. Goals
b. Objectives
c. Treatment modalities
d. Interventions
e. Projected target dates for completion of treatment
f. Cultural issues
g. Client/Guardian strengths and commitment to participate in treatment
h. Justification for extension of services
i. Updated CANS for all wraparound services

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

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

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

E. REQUEST FOR PSYCHOLOGICAL TESTING

1. If the Network Provider believes psychological testing is indicated, the provider will contact the MHP to request authorization. The beneficiary's completed initial assessment and a written rationale for the request for psychological testing should be evaluated by MHP to determine the appropriateness of the request.

2. If the request is authorized, a preset number of hours for administering, scoring, and report writing will be given by the MHP.

3. If the request is determined to be unnecessary the MHP will notify the provider of the decision and the reasons for denial. An NOA-B (Attachment P) will be sent by the MHP to the beneficiary.

F. AUTHORIZATION AND REIMBURSEMENT REQUESTS FOR TIME SPENT DOING COURT LETTERS, REPORTS, AND TESTIMONY

1. Upon notice from the legal system that a letter, report, or direct testimony is to be given regarding a client of a provider , the provider must contact the MHP to request authorization prior to completing such services.

2. The provider will give a reasonable estimate as to how much time it will take to provide the needed information/testimony.

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

4. Once the provider has completed authorized services; s/he will use a Madera County Mental Health Plan **"Madera County Mental Health Billing Forms"** to bill for the services (Attachment E). Invoices for authorized court services must be sent to the MHP within one year after the last item was accrued.

G. NOTICE OF ACTION (NOA-A, NOA-B, NOA-C, NOA-D. NOA-E)

1. When during an assessment, it is determined by the provider that the client does not meet the medical necessity criteria; the provider will send the completed assessment to the MHP within twenty four (24) hours.

   a. The MHP will send an NOA-A (Attachment O), to the beneficiary and the provider.

   b. The NOA-A indicates a reason for the denial and the appeal procedure.

2. The MHP may decide client services will no longer be authorized if the following occurs during treatment: the client no longer has a covered Medi-Cal diagnosis; the client is not benefiting from treatment; the client appears to have successfully completed treatment. If request for services is reduced or denied, the MHP will send an NOA-B (Attachment P) to the beneficiary within three (3) days.

3. A Notice of Action – Post Service Denial of Payment (NOA-C) form (Attachment Q) 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.

   a. When services are provided to Medi-Cal beneficiaries prior to authorization by the MHP, the Specialty Mental Health provider will submit to the MHP a Treatment Authorization Request (TAR) (Attachment Q). The TAR must be accompanied by documentation to support medical necessity criteria.

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

   c. If the MHP determines that medical necessity criteria were not met for any or all services provided, payment will be denied for those services.

   d. An original NOA-C (Attachment G) will be mailed or delivered to the beneficiary by the MHP within 3 working days of the decision.

The NOA-C will inform the beneficiary of his/her right to appeal the decision and receive a State Fair Hearing.

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

4. A Notice of Action – Delays in Grievance/Appeal Processing (NOA-D) form (Attachment R) 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.

   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 or given to the beneficiary on the date that the timeframe expires.

   b. The NOA-D will inform the beneficiary of his/her right to request a State Fair Hearing to consider the reason for the delay in the resolution of a grievance or appeal, or in the case of a grievance to file an appeal. Beneficiary may request a State Fair Hearing once the appeal process has been exhausted.

   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.

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

   a. The original NOA-E form will be sent to the beneficiary, and a copy will be placed in the MHP files within 5 working days of the MHP notification that services have not been provided.

   b. The NOA-E will inform the beneficiary of his/her right to a State Fair Hearing, following the exhaustion of the appeal process.

H. EMERGENCY SERVICES

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

I. BENEFICIARY GRIEVANCES AND APPEALS

1. **Mental Health Plan Brochure (Attachment J3)**
When a beneficiary first receives non-emergency specialty mental health treatment services through the Madera County MHP, staff will provide the beneficiary (either in person or by mail) with a brochure, which describes the program, the process for obtaining services through the program, and the process for resolving grievances and appeals.

2. Questions and Concerns (Attachment J1)
Beneficiaries are encouraged to discuss concerns about mental health services with their provider or MHP staff. Beneficiaries may also talk to

the Quality Management Coordinator at (559) 673-3508, (888) 275-9779; or TTY (800) 735-2929 call the Patients' Rights Advocate at (559) 661-5194; or call California Department of Mental Health Ombudsmen at (800) 896-4042, TTY (800) 735-2929. A consumer representative may also be contacted for assistance with forms by calling 673-3508, toll free (888) 275-9779 or TTY (800) 735-2929. (Attachment N)

3. Grievance Procedure (Attachment J2)

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

4. Appeal Procedure

A beneficiary may appeal an "action" by the Mental Health Plan by calling the Quality Management Coordinator at (559) 673-3508 or toll free at (888) 275-9779, or TTY (800) 735-2929. An 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 provide services in a timely manner, as determined by the MHP.
- Fails to act within the timeframes for disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals.

9. MENTAL HEALTH PLAN RESPONSIBILITIES

A. THE MENTAL HEALTH PLAN WILL:

1. Provide a 24-hour toll-free telephone line for screening information. (888) 275-9779 or TTY (800) 735-2929 CALLERS WITH EMERGENCY SITUATIONS SHOULD CALL BHS EMERGENCY SERVICES 911

2. Return beneficiary non-emergency phone calls within four working hours of receipt.

3. Provide telephone screening for all persons who request or are referred for specialty mental health services. The MHP calls the providers selected by the beneficiary and provides the name of the client and their phone number.

4. Send the provider a notification packet (Attachment D1, D3 or D4, D5) which identifies the client name, phone number and address. It includes forms for the assessment, billing, discharge, and HIPAA privacy statement (Attachment Q) to be signed by the beneficiary. A copy of the

signed HIPAA document is to be placed in the network provider's medical record for the beneficiary. The original signed document is to be returned to the MHP with the first claim form.

5. Maintain written and verbal communication with providers regarding status of authorizations.

   a. Verbal confirmation of initial authorization will be telephoned to provider, within one working day, but not later than three (3) working days.

   b. Written confirmation of initial authorization will be mailed or faxed to beneficiary and provider within seven calendar days of receipt of request for service.

   c. Reauthorizations will be mailed or faxed to the provider within seven calendar days of receipt of request for reauthorization.

6. After three months or twenty-fourth (24) client visit, an MHP clinician will arrange to review the client's chart.

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

7. The Quality Management Coordinator (QMC) will schedule quality chart reviews in the provider's office or the provider may mail the chart to the QMC ensuring the beneficiary's confidentiality. (See Attachment C)

   a. The MHP and QM staff will, whenever possible, coordinate their times for chart reviews to minimize inconveniencing the provider.

8. The MHP will provide the Network Provider with a supply of MHP brochures including Services Guide. (Attachment I3) Providers are required to make these available to beneficiaries in their waiting areas.

9. The QM clinician will track beneficiary appeals and grievances.

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

10. PROVIDER RESPONSIBILITIES

A. PROVIDERS WILL:

1. Offer an appointment for an assessment with an authorized beneficiary

within five working days of the beneficiary's request for services unless the beneficiary requests a later appointment.

2. Inform all inquiring beneficiaries of the requirement for MHP authorization prior to beginning a course of treatment.

3. Assist beneficiaries in obtaining from the MHP a list of community mental health resources. They include, but are not limited to:

   a. List of credentialed mental health providers.

   b. List of physical health care providers.

   c. Adjunct services supportive to mental health, including:

      - Case Management
      - Therapeutic Behavioral Services
      - Medication evaluation and monitoring
      - Katie A services
      - Wraparound provider(s) (SB163)
      - Drug and Alcohol Services
      - Vocational Rehabilitation Services
      - Housing Authority
      - Social Services
      - Food Banks
      - Services for the Elderly (limited)
      - Parenting Classes
      - Anger Management Classes
      - Self-Help Support groups
      - Others which may be obtained from the MHP office.

4. Provide the MHP with all requested information in order to expedite requests for reauthorization of services.

5. Provide only those services to beneficiaries that are specified and authorized by the MHP.

6. Assure that services are provided to beneficiaries who remain eligible for Medi-Cal reimbursement. (The MHP may assist in verification of eligibility at the beginning of each month.)

7. Obtain beneficiary or parent/guardian signature on Reauthorization Requests (B2, B3 or B4, B6) to demonstrate beneficiary's participation in and agreement with Treatment Plan specified.

8. Maintain clinical records according to the following standards:

   a. Each beneficiary will have a separate medical record.

   b. All pages in the record will be filed chronologically.

   c. Each page in the record will contain the beneficiary's name and

ID number for identification.

d. Each record will be legible and written in black ink (or typed). White-out is not allowed in the medical record.

9. Make clinical records available to staff of the BHS and the State Department of Mental Health upon request and send a plan of correction with evidence of the changes upon MHP request after the chart review.

10. Report all unusual occurrences to the Behavioral Health Director/Designee at (559) 673-3508. (Attachment G)

    a. An unusual occurrence is defined as any event that jeopardizes health and/or safety of consumers, staff, and/or members of the community, including, but not limited to physical injury and death. An example of an unusual occurrence includes, but is not limited to, epidemic outbreaks, poisonings, fires, major accidents, death from unnatural causes or other catastrophes.

11. Notify the Behavioral Health Director/Designee at (559) 673-3508 of any suicide or homicide of a consumer that has been referred to them by the MHP for mental health services. (Attachment H)

12. Assist beneficiaries who do not have a primary care physician to obtain one.

13. Coordinate mental health services and physical health care with the primary care physician (PCP).

14. Network Providers must offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid fee-for-service, if the provider serves only Medicaid beneficiaries. There should be no discrimination against Medi-Cal beneficiaries, e.g., appointment times limited to specific hours of the day/week compared to other clients with other funding sources.

B. PROGRESS NOTES

1. Progress notes for mental health clients will be included in all client records for specialty mental health services.

2. Client progress notes must include the following:

    a. Timely documentation of relevant aspects of client care.

    b. Client encounters, including relevant clinical decisions and interventions.

    c. Signature of the person providing the service (or electronic equivalent) and the person’s professional degree, licensure or job

title after each chart entry.

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

4. Information regarding HIV status is not to be written in the document.

C. DISCHARGE SUMMARY

1. A Discharge Summary (Attachment D) will be included in the client record.

2. A copy of the Discharge Summary must be returned to the MHP office with the final claims.
   a. Failure to complete and return Discharge Summary may result in non-payment for final claims.

D. SITE VISITS CERTIFICATION AND CREDENTIALING

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

11. REQUEST FOR PSYCHIATRIC CONSULTATION/PSYCHIATRIC INPATIENT EVALUATION

A. PSYCHIATRIC CONSULTATION

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

B. INPATIENT ADMISSIONS

1. When a provider assesses that a Medi-Cal beneficiary may be in need of inpatient psychiatric hospitalization because s/he is:
   - a danger to self, or
   - a danger to others, or
   - gravely disabled,

   the provider will call BHS at (559) 673-3508, 1(888) 275-9779 or TTY 1 (800) 735-2929 and ask to speak to a crisis worker.

   a. The provider will:
      - identify himself/herself and the client
      - give the client's phone number and address
      - provide an assessment of the client's current circumstances and status requiring hospitalization

   b. The crisis worker will talk to the client and evaluate the client to insure that medical necessity criteria for inpatient hospitalization is met. If indicated, the crisis worker will facilitate hospitalization with a contracting hospital if required.

2. If the provider disagrees with the crisis worker's evaluation, the provider may call the MHP at (559) 675-3508, 1 (888) 275-9779 or TTY 1 (800) 735-2929 and ask to speak with Mental Health Administration staff.

3. Planned admissions must be pre-authorized by contacting MHP.

12. MEDICATION EVALUATION

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

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

13. CONFIDENTIALITY

Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42, CFR, Section 431.300 et. seq., Sections 5328 and 14100.2, Welfare and Institutions Code and in accordance with contract agreements. All information, records, data and data elements pertaining to beneficiaries must be protected by the provider from unauthorized disclosure. In accordance with HIPAA requirements, a Notice of Privacy Practices (Attachment B) will be handed or mailed to all beneficiaries who are referred to a network provider. In addition, a Notice of Privacy Practices will be sent to the provider to be signed by the beneficiary. A copy of the signed HIPAA document is to be placed in the network provider's medical record for the beneficiary. The original signed document should be returned to the MHP with the first claim form.

14. PAYMENT POLICIES AND PROCEDURES

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

1. Services were pre-authorized by the MHP in accordance with contract agreements.

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

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

4. Claims were submitted in accordance with contract agreements.

5. A discharge summary (Attachment O) was sent on or before the final claim for payment.

6. A separate claim form (Attachment D3) covering only one fiscal year has been submitted for each beneficiary, which includes the beneficiaries identification number, provider number, time of service, date of service, and duration of each service.

7. The first billing was submitted with a completed Assessment (Attachment B5) and the HIPAA Notice of Privacy Practices (Attachment Q) signed by the beneficiary or legal guardian.

B. Payments will be mailed to providers in accordance with contract agreements.

C. Payment requests should be made using an MHP, HCFA 1500 (Attachment E) or an appropriate HIPAA format claim form.

D. Completed forms should be mailed to:

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

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

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

15. QUALITY MANAGEMENT AND UTILIZATION REVIEW

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

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

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

16. BENEFICIARY GRIEVANCES/APPEALS

The Consumer Rights and Problem Resolution Guide (Attachment J1) describe how beneficiaries/consumers who are not satisfied with their services may file grievances or appeals. (Attachments N)

17. PROVIDER COMPLAINT AND APPEAL PROCEDURES

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

A. DEFINITIONS

1. **Services** include inpatient or outpatient Medi-Cal mental health services.

2. **Complaint** is a statement registered by a provider regarding a problem that can be resolved informally

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

4. **Provider** is a mental health provider who has a contract with the MHP to provide services to Medi-Cal beneficiaries.

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

B. COMPLAINT PROCESS

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

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

   b. Delay of payments.

   c. Lack of information or cooperation by MHP staff.

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

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

   f. Other issues as determined by the provider.

2. A provider may present a complaint to the MHP Division Manager or designee by telephone, in person, or in writing.

   a. The MHP Division Manager will attempt to resolve the complaint. Suggested solutions will be provided to the complainant within two weeks from receipt of the complaint.

   b. If the provider is not satisfied with the response, the provider may file an appeal under the circumstances listed in “C” below.

C. APPEALS: FORMAL PROBLEM RESOLUTION PROCESS (Attachment C)

1. Denial of authorization for services.

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

   b. The written appeal shall be submitted to the Behavioral Health

Director or designee within thirty (30) calendar days of the postmark date of the notification of the denial.

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

d. The Behavioral Health Director or designee will have thirty (30) days from the postmark or fax date of receipt of the appeal to complete an evaluation of the appeal.

e. 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.

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

2. Denial of claims payment.

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

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

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

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

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

3. Problem Resolution Log

The Behavioral Health 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 to the County Mental Health Quality Improvement Committee. 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, and date for resolution or disposition of the problem. These records will be open to review by the State DMH, State Department of Health Services, and the Federal oversight agency. 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.

4. Use By Other Providers

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

D. CONTACT PERSON

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

Quality Management Coordinator
Madera County Behavioral Health Services
P.O. Box 1288
Madera, CA 93639-1288
(559) 673-3508; FAX (559) 661-2818
TTY (800) 735-2929

18. PROVIDER CREDENTIALING PROCESS

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

A. A provider will be re-credentialed every two years and monitored to insure standards of the MHP are met.

B. It is the responsibility of all providers to continue to meet the standards set forth by the MHP. Failure to do so may be grounds for suspension or revocation of credentialing by BHS.

C. If a clinician fails to meet the standards set forth by the Board of Behavioral Science Examiners his/her clinical privileges with Madera County will be revoked.

D. See attached copies of credentialing procedures. (Attachment T)

19. PROVIDER UPDATES

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

20. INSTITUTE FOR MENTAL DISEASE (IMD)/SKILLED NURSING FACILITY (SNF) PSYCHIATRIC SERVICES/MENTAL HEALTH REHABILITATION CENTER (MHRC)

A. SCREENING AND AUTHORIZATION

1. When a Madera County client is admitted to an IMD, SNF, or MHRC, BHS staff will complete a Screening and Disposition form indicating the names of the facility and the psychiatrist who will provide services.

2. The Screening and Disposition form (Attachment R2) will be sent to the MHP within two (2) working days of admission.

3. The MHP clinician authorizes a limit of three (3) sessions per month.

    1. More than three (3) sessions in one (1) month must be pre-authorized by the MHP.

4. Psychiatrist billings must be accompanied by a copy of the psychiatrist's clinical note for each visit (the assessment will be sent as verification of the first visit).

5. Claims must be submitted by the end of the month following the visits for which the psychiatrist has billed.

21 BENEFICIARY RIGHTS

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

22 ADVANCE DIRECTIVES

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